CBT DISTINCTIVE FEATURES

Cognitive Behavioural Chairwork

Distinctive Features

MATTHEW PUGH

"Occasionally a book is written that fills such a big hole that you wonder how it hasn't been written before. When it is also so practical and written with such clarity, you know it is something special. *Cognitive Behavioural Chairwork* is such a book. Of all experiential processes in CBT, chairwork is amongst the most powerful, yet least well articulated. Dr. Pugh has produced an elegant, beautifully constructed book that traverses the history, theory and practice of chairwork in an extraordinarily accessible way."

– Professor James Bennett-Levy, PhD, University of Sydney, author of *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*

"Part of the role of psychotherapy is to help clients differentiate, tolerate and integrate different processes within themselves. Inviting them to adopt, become, and enact different parts – be they emotions, motives, or even memories – is increasingly recognised as a core therapeutic process. In this exceptionally insightful, clear, and useful book, Dr. Pugh skilfully guides the therapist through the history of chairwork and its different forms and functions. Full of fascinating clinical insights and wisdoms, along with step-by-step guidance in this way of working, this text is a must-read. I will return to the book many times."

– Professor Paul Gilbert, OBE, Founder and President, Compassionate Mind Foundation, author of *The Compassionate Mind*

"*Cognitive Behavioural Chairwork* is an invaluable resource, especially in enhancing your ability to help clients change their cognitions, at both the intellectual and emotional level, in order to bring about enduring change in their mood and functioning. Excellent case examples illustrate the rationale for chairwork and teach you how to use your conceptualization to integrate specific evocative techniques. I highly recommend this book!"

– Professor Judith S. Beck, PhD, President, Beck Institute for Cognitive Behavior Therapy, Clinical Professor, University of Pennsylvania, author of *Cognitive Therapy: Basics and Beyond*

"In this important volume, Dr. Matthew Pugh has integrated his vast knowledge of the cognitive behavioural therapies with what he has learned from his chairwork practice. Filled with succinct and compelling vignettes, this book will empower therapists to help patients heal their internal conflicts, reduce their self-hatred, work through traumatic and disturbing memories, confront difficult interpersonal challenges, and overcome their fears of self-expression. For those interested in chairwork and/or CBT, this book is a gift."

– Scott Kellogg, PhD, Transformational Chairwork, New York City

"This state-of-the-art book gives the most comprehensive overview of different forms of chairwork that can be used in CBT, covering working mechanisms as well as practical applications. A must-read for therapists who want to extend their repertoire with this powerful experiential method, that reaches the emotional core directly."

– Professor Arnoud Arntz, PhD, University of Amsterdam, author of *Schema Therapy in Practice: An Introductory Guide to the Schema Mode Approach*

Cognitive Behavioural Chairwork

Cognitive Behavioural Chairwork: Distinctive Features provides a practical, accessible, and concise introduction to both the theory and practice of chairwork, one of the most powerful and exciting methods of intervention in cognitive behavioural therapy (CBT), and is the first book to synthesise its many applications in CBT and allied therapies.

Part of the popular 'CBT Distinctive Features' series, this book contains a wealth of effective experiential procedures for working with automatic thoughts, emotions, behaviours, core beliefs, ambivalence, strengths, well-being, and cognitive processes such as worry and self-criticism. Readers will also learn how chairwork is applied in other areas, such as clinical supervision and associated psychotherapeutic approaches including compassion focused therapy, schema therapy, positive psychotherapy, and motivational interviewing. Techniques are presented in an easy-to-understand format and illustrated using clinical examples and therapy transcripts. The result is a comprehensive guide which demystifies chairwork and places it at the heart of CBT's continued evolution.

Created for practising clinicians, researchers, and training therapists, *Cognitive Behavioural Chairwork: Distinctive Features* will appeal to both individuals who are new to chairwork and those who are familiar with its techniques.

Matthew Pugh is a Clinical Psychologist, Cognitive Behavioural Psychotherapist, and Advanced Schema Therapist. He works with the Vincent Square Eating Disorders Service (Central and North West London NHS Foundation Trust) and is an Honorary Clinical Lecturer with University College London.

CBT Distinctive Features

Series Editor: Windy Dryden

Cognitive behaviour therapy (CBT) occupies a central position in the move towards evidence-based practice and is frequently used in the clinical environment. Yet there is no one universal approach to CBT, and clinicians speak of first-, second-, and even third-wave approaches.

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Cognitive Behavioural Chairwork

Distinctive Features

Matthew Pugh

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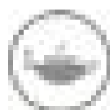
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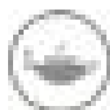
Part I

THEORETICAL FEATURES OF COGNITIVE BEHAVIOURAL CHAIRWORK



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1

A brief history of chairwork

Chairwork represents a collection of experiential interventions which utilise chairs and their relative positions for therapeutic purposes. Devised over a century ago, chair-based techniques are now employed in numerous contemporary psychotherapies including cognitive behavioural therapy (CBT) (Pugh, 2017), experiential therapy (Greenberg, Rice, & Elliott, 1993), psychodynamic therapy (Fosha, 2000), and family therapy (Tsvieli & Diamond, 2018). In fact, few interventions seem as ubiquitous to talking therapy as chairwork (excluding the therapeutic relationship, of course). This book opens with a review of the provenance and evolution of these techniques over time.

Jacob L. Moreno and 'psychodrama'

Chairwork was conceived by Jacob L. Moreno (1889–1974), the founder of psychodrama. Moreno first studied psychoanalysis but promptly rejected many of its principles, including its reliance on discourse. "You analyse [people] and tear them apart", he is reported to have told Sigmund Freud. "I let them act out their conflicting roles and help them to put the parts back together" (Moreno, 2014, p. 50). Moreno believed that perception was principally nurtured through action and so was most amenable to change via enactment. Theatre and performance, he argued, provided a means to recreate, observe, and resolve personal troubles. Given the prevailing orthodoxy of psychoanalysis at this time, Moreno's ideas were nothing short of revolutionary.

Beginning in the 1920s, Moreno employed action-based methods to help "transform the clinical consulting room into a theatrical

stage" (Landy, 2008, p. 197). These principles would form the basis of psychodrama: a group psychotherapy which his wife, Zerka, later refined. Under the guidance of a facilitator (the 'director'), psychodrama sessions involved the group working through the problems of a member (the 'protagonist'). To facilitate this process, experiential techniques were employed to externalise aspects of the client's internal world. These included mirroring (observing one's behaviour re-enacted by another individual), doubling (hearing one's internal voice spoken by a group member), and dialoguing with absent individuals represented by an empty chair (Moreno, 2014). These methods proved highly influential: as Eric Berne notes, "nearly all 'active' techniques were first tried out by Moreno in psychodrama so that it is difficult to come up with an original idea in this regard" (Berne, 1970, p. 164).

George Kelly and 'personal-construct therapy'

American psychologist George Kelly (1905–1967) was influenced by Moreno's work. Like Moreno, Kelly rejected much of psychoanalysis and contended that clients' actions were more paramount to emotional distress than their history (Fransella & Neimeyer, 2005). In 1955, Kelly outlined personal construct therapy (PCT) – described by some as a convergence of behaviourism and psychodrama (Griffith, 2003) – which embraced a constructivist view of personality. In essence, Kelly believed that people created themselves and their worlds and could therefore recreate themselves when these usual 'roles' became problematic.

A quintessential intervention in PCT, 'fixed role therapy' (Kelly, 1955) involved an examination of the client's current identity or 'construct' alongside the creation of a new persona (a 'role sketch'). This new character would then be rehearsed through role-play and enacted in daily life for a specified period. Kelly (1955) hoped that immersion in this novel role would provide clients with a "construct shaking experience" (p. 412), demonstrating that change was possible and entrapment in one's autobiography could be overcome

(Neimeyer & Winter, 2007). Kelly's work would later influence technical and conceptual elements of Beck's cognitive therapy including behavioural rehearsal, role-play, and experimentation (Beck, 1976).

Frederick "Fritz" Perls and 'gestalt therapy'

Outspoken, irreverent, and confrontational, Fritz Perls (1893–1970) remains a controversial figure in psychotherapy. Initially trained as a psychoanalyst, Perls later established gestalt therapy in the 1950s. Prior to this, Perls trained with Moreno and regularly attended psychodrama sessions in New York. It was here that he was introduced to chairwork (Kellogg, 2015), techniques which were later centralised in his gestalt approach.

Whilst Perls's relationship with Moreno was at times strained, both individuals shared similar conceptualisations of therapeutic change. For Perls, emotional conflicts could only be resolved if their manifestations were made apparent in the 'here-and-now'. These ideas spurred his rejection of intellectualisation and 'aboutism' in psychotherapy; rather than 'talking about' their problems, Perls believed that clients needed to 'talk to' these issues (Perls, 1969). "It is insufficient to recall a past incident", Perls (1973, p. 65) states, "one has to psychodramatically return to it".

Like Moreno, Perls was also a consummate performer. Throughout the 1960s, he provided demonstrations of gestalt chairwork in well-attended workshops. Many chairwork techniques were popularised by these performances including two-chair dialogues between clients' polarised 'top-dog' and 'under-dog' (i.e. the critical and criticised parts of the self) and empty-chair dialogues with other individuals ('unfinished situations'). However, Perls's use of the chair deviated from psychodrama in one crucial aspect: rather than inviting other individuals into chairwork, clients would be asked to enact all roles in the 'hot-seat' (Perls, 1969). In proposing this, chairwork shifted from being a principally group-focused intervention to one which could be applied in individual therapies.

Leslie S. Greenberg and 'process-experiential/ emotion-focused therapy'

Whilst Moreno, Kelly, and Perls elegantly demonstrated the 'art' of chairwork, Leslie Greenberg has clarified the 'science' of these techniques. Greenberg first trained in person-centred therapy before studying gestalt therapy with Perls's wife, Laura. Greenberg was impressed by the transformative power of chairwork but frustrated by a lack of guidance regarding its implementation, rendering it "unteachable in any systemic way" (Greenberg, 1979, p. 316).

Seeking to demystify these techniques, Greenberg began conducting chairwork-related research in the 1970s. This has continued into the 21st century and has helped establish the clinical effectiveness of these techniques and their mechanisms of change (see Chapter 15). Greenberg's research has also informed the development of process-experiential therapy (Greenberg et al., 1993) and emotion-focused therapy (Elliott, Watson, Goldman, & Greenberg, 2004), both of which combine chairwork with Rogers' (1951) therapeutic conditions for growth: ingredients which early gestalt approaches sometimes lacked (Leslie Greenberg, personal communication). As we shall see, Greenberg's contributions have also influenced applications of chairwork in CBT and 'integrative' forms of cognitive psychotherapy.

2

Chairwork in cognitive and behavioural therapies

Despite its rich history of applications, many CBT therapists are unfamiliar with chairwork. To contextualise the inclusion of these techniques in clinicians' technical repertoires, this chapter charts the development of chairwork in cognitive therapy and allied psychotherapeutic approaches.

Behaviour therapy

Behavioural therapy (BT) emerged in the 1950s with the intention of modifying maladaptive behaviour. One of the first behavioural interventions widely applied by clinicians, assertiveness skills training sought to alleviate clients' social and emotional inhibitions by encouraging a "return to excitation" (Salter, 1949, p. 39). These ideas were extended by Wolpe (1958) who theorised that assertiveness generated therapeutic effects through the "reciprocal inhibition of anxiety" (p. 115). To help clients develop their assertiveness skills, Wolpe regularly employed in-session 'psychodramas'. This precedent would prompt widespread use of behavioural rehearsal in BT (Lazarus, 1963) – a term behaviourists seem to have favoured more than psychodrama. Informed by theories of social learning (Bandura, 1969), these experiential methods were later broadened to include modelling, coaching, 'contrasted' role-plays, and 'exaggerated' behaviour rehearsal (McFall & Twentyman, 1973; McNeilage & Adams, 1979).

Rational emotive behaviour therapy

Often considered a forerunner to CBT, Albert Ellis's 'rational therapy' (now rational emotive behaviour therapy [REBT]) proposed that psychological disturbance originated from underlying irrational beliefs. Developing a rational perspective on one's problems, Ellis argued, could alleviate distress and encourage behaviour change (Ellis, 1962). Whilst disputing irrational beliefs often proved effective, Ellis observed that some remained resistant to change. In these circumstances, he recommended that 'forceful' chairwork techniques be used to bring irrational beliefs into sharper focus and ensure their disputation was memorable (Ellis, 2004). Interestingly, it was the adoption of these evocative interventions that partly inspired Ellis to rename his approach 'rational-emotive therapy' (Ellis, 2001). Several influential chairwork techniques have since emerged from REBT including role-reversal and rational-emotive dialogues (Dryden, 1995).

Cognitive therapy

Beck's cognitive model, which aimed to generate symptomatic relief through cognitive modification, represented a radical departure from BT (Clark, 1995). Over time, Beck's cognitive therapy (CT) was gradually adopted by many behaviourists, leading to an assimilation of first-wave BT and second-wave CT ('cognitive behavioural therapy') (Hayes, 2004). Whilst cognitive interventions where centralised in CT, Beck (1991) believed these "by no means [defined] the limits of cognitive therapy" (p. 195). Assuming that other techniques remained compatible with its underlying principles, technical eclecticism was welcomed in CT. Experiential interventions such as chairwork, which exposed the client to transformational experiences, were regarded as a particularly effective means to accelerate cognitive modification (Beck, 1976). Second only to behavioural interventions, gestalt and psychodrama techniques appeared to be the chief integrations in early CT (Beck,

Emery, & Greenberg, 1985; Beck, Rush, Shaw, & Emery, 1979). Indeed, Beck has since acknowledged that his use of "enactive, emotive strategies was influenced, no doubt, by psychodrama and gestalt therapy" (Beck, 1991, p. 196).

Cognitive treatments for complex presentations were elaborated throughout the 1990s (e.g. Beck et al., 1990; Young, 1990). These longer-term therapies advocated the use of active and evocative schema-level interventions in difficult-to-treat disorders, including chairwork. Emerging theories of cognition and affect also provided sophisticated rationales for the inclusion of these techniques, including a need to work with 'hot' cognitive material, the limits of analytic interventions when applied to primitive schematic structures, and the importance of emotional arousal in enabling cognitive modification (Arntz & Weertman, 1999; Safran & Greenberg, 1982; Teasdale & Barnard, 1993). Consequently, chairwork was often recommended when 'traditional' cognitive interventions proved ineffective (Beck, 1995).

The emergence of allied approaches

The 1990s also saw a new generation of allied psychotherapies emerge (previously referred to as a 'third-wave' of cognitive therapy; Hayes, 2004). These included acceptance and commitment therapy (ACT), compassion focused therapy (CFT), and dialectical behaviour therapy (DBT). Whilst markedly different in many aspects, these approaches shared certain principles in common including the therapeutic role of acceptance, non-judgemental awareness, and metacognitive processes (Gilbert, 2010; Hayes, Strosahl, & Wilson, 2012; Linehan, 2015). Also defining of this new generation of therapies was growing appreciation for the role of 'self-multiplicity'. Whilst CBT had previously referred to the existence of multiple 'mindsets' and 'modes' of information processing (Beck, 1996; Teasdale, 1997), working directly with parts of the self had rarely been a focus for treatment. In contrast, third-wave approaches embraced this multifaceted and dynamic model of

selfhood (see Chapter 6). To help disentangle, concretise, and stimulate interactions between self-parts, many third-wave approaches incorporated chairwork as core therapeutic intervention. In doing so, dialogical models of cognitive-affective change, involving self-parts engaging in meaningful exchanges with other self-parts, were recognised in CBT.

'Integrative' cognitive therapy

Descriptions of how CT could be combined with experiential psychotherapies emerged shortly after its development (Arnkoff, 1981; Edwards, 1989). These 'integrative' approaches were justified on several grounds including shared principles of change (e.g. discovery through experience), implementation strategies (e.g. collaborative working), and, more recently, the hypothesis that affect-focused techniques such as chairwork could enhance CBT by encouraging more productive emotional processing (Newman et al., 2011). Supporting these assertions, research indicates that CBT combined with gestalt and emotion-focused chair technique is capable of generating promising results (see Chapter 15).

Process-based CBT and core competencies

Modern CBT appears to be moving away from protocol-driven interventions and towards the application of evidence-based procedures for core psychological processes (Hofmann & Hayes, 2018). Similarly, CBT therapists are expected to utilise generic and disorder-specific 'core competencies' to ensure treatments are evidence based and theoretically informed (Roth & Pilling, 2007). Whilst chairwork has received some recognition within process-based and competency-focused frameworks (e.g. Arntz, 2018), opportunities to train in these techniques remains limited. In addition, many processes associated with cognitive behavioural

chairwork (e.g. self-multiplicity, personification, and embodiment) are yet to be recognised by these approaches.

The future of chairwork in CBT

Integrating experiential methods into CBT represents an important direction for its continued development. Consistent with this endorsement, cognitive therapies which utilise chairwork as a primary method of intervention have emerged in the last decade (de Oliveira, 2015; Hayward, Overton, Dorey, & Denney, 2009). These developments raise important questions. Should chairwork become a more routine feature of CBT? Will these techniques undergo the same empirical scrutiny as other experiential techniques such as imagery? Could a 'dialogical' approach to CBT emerge, which centralises self-to-self and self-to-other dialogues through the medium of chairwork? Only time will tell.

3

Forms of chairwork

Chairwork techniques have been differentiated according to how chairs are utilised in therapy. *Empty-chair*, *multi-chair*, and *role-play* techniques are most commonly used in CBT.

Empty-chair techniques

Empty-chair techniques involve the client speaking with an ‘other’ held, symbolically, in an empty seat. Typically this ‘other’ will relate to individuals the client has known. For example, empty-chairwork might be used to confront an abusive parent implicated in the development of a negative core belief. Empty-chair techniques are also used to facilitate dialogues with parts of the self. Alleviating self-criticism, for example, might be enhanced by challenging one’s ‘inner critic’, represented by an empty chair. Lastly, empty-chairwork enables dialogues with more abstract representations including one’s emotional states, goals, and values.

> Jane linked her core belief “I am incompetent” to comments made by a critical teacher at school. Modifying this belief involved Jane imagining her teacher in an empty chair and then confronting her.

Multi-chair techniques

Multi-chair techniques involve the client speaking from two or more chairs representing specific thoughts, feelings, perspectives,

or motivations. For example, two-chair cognitive restructuring invites the client to present the evidence supporting a negative automatic thought (NAT) in chair one, followed by counter-evidence in chair two. Complex interventions requiring three or more chairs have also been described. Dialogues between the 'Critical Self', 'Criticised Self', and 'Compassionate Self' are often utilised in CFT, for example.

> Kabir's self-criticism was maintained by the metacognitive belief, 'self-criticism makes me work harder'. To test out this belief, Kabir changed seats and enacted his typical self-critical thoughts in the second-person ("Stop being so sloppy, you idiot"). Returning to his first chair, Kabir described feeling anxious and demoralised in response to these attacks. This exercise highlighted the detrimental effects of self-criticism and led Kabir to question its supposed utility.

Role-play

Chair-based role-plays allow individuals to examine and rehearse self-to-self and self-to-other interactions. *Interpersonal role-plays* involve acting or re-enacting interactions involving other individuals. This might be with a view to practice new behaviours, improve perspective-taking, or make sense of problematic social experiences.

> Jane was anxious about asking her housemate for unpaid rent. To build her confidence, she and her therapist used role-plays to rehearse initiating this conversation.

Intrapersonal role-plays (sometimes referred to as 'voice dialogue' or 'diagnostic interviewing') invite the client to enact parts of the self. These role-plays tend to be used for the purposes of assessment and functional analysis in CBT.

Kabir worried excessively before social interactions. To better understand the functions of worry, Kabir was asked to switch seats and to speak from the perspective of his 'worrying side'. When asked what it was hoping to achieve, Kabir's worrying side disclosed that its intention was to help him prepare for social events and thus ensure that he made a good impression on others.

In *symbolic role-plays*, the client (and sometimes the therapist) adopt allegorical roles. Lawyer-prosecutor dialogues are probably the most well-known form of symbolic role-play in CBT.

Jane's therapist proposed using a lawyer-prosecutor role-play to examine her thought, "I will never recover from my eating disorder". First, Jane played the role of a 'prosecuting attorney' and presented evidence in support of this NAT. Next, she switched seats and played the role of a 'defence attorney', presenting evidence which did not support this thought.

External versus internal dialogues

Kellogg (2015) suggests that how chairs are used in psychotherapy is somewhat extraneous. Rather, chairwork techniques are better differentiated according to the forms of dialogue they enable. *External dialogues* (or 'interpersonal chairwork') involve using chairs to speak with persons from the past, present, or future, whilst *internal dialogues* (or 'intrapersonal chairwork') involve speaking with parts of the self.[1]

Integrating forms of chairwork

Therapists will often find themselves integrating multiple forms of chairwork within a single intervention. To illustrate, exploring the evidence for and against a core belief using two-chair cognitive restructuring (an internal dialogue) could readily lead to challenging individuals who contributed to the formation of this belief using empty-chair techniques (an external dialogue). As treatment progresses and familiarity with chairwork grows, clients are encouraged to take ownership over when and how these techniques are employed in CBT.

Note

1. Kellogg (2018) has recently integrated the dichotomies of internal versus external dialogues and single versus multi-chair interventions to produce a 'four dialogue matrix' of chairwork techniques. These relate to: (1) single-chair interventions involving an isolated part of self ('giving voice'; see intrapersonal role-play in Chapter 21 for an example); (2) multi-chair interventions involving dialogues between different parts of the self ('internal dialogues'; see two-chair decisional balancing in Chapter 24 for an example); (3) single-chair interventions involving the disclosure of painful or traumatic experiences ('telling the story'; see adaptive disclosure in Chapter 27 for an example); and (4) multi-chair dialogues involving other individuals ('encounters and enactments'; see historical role-play in Chapter 22 for an example).

4

Forms of facilitation

Chairwork techniques vary according to their manner of facilitation (Kellogg, 2015). *Corrective dialogues* aim to modify aspects of the client's internal world. These techniques tend to be structured and require a *directive, goal-orientated* style of facilitation. In contrast, *exploratory dialogues* aim to help the client grow in insight and awareness. These unstructured forms of chairwork require a *reflective* style of facilitation so that organic dialogues can emerge.

In CBT, chairwork techniques are used to achieve specific goals. These include assessment of the client's presenting difficulties; developing the case conceptualisation; modifying dysfunctional thoughts, feelings, and behaviours; and evaluating treatment outcomes. Given their specificity, structured and corrective chairwork techniques tend to dominate in this approach. To facilitate this style of chairwork, CBT therapists usually adopt a fairly directive role – at times prompting the client and actively intervening at other points – to ensure the intervention achieves its particular objectives.

Session one: an exploratory chairwork dialogue

Kabir did not understand why he felt so hesitant about accepting a promotion at work. His therapist suggested using a two-chair technique to clarify the reasons for his ambivalence. Kabir first presented reasons in favour of accepting the promotion in chair one, followed by reasons in favour of declining the promotion in chair two ('two-chair decisional balancing'; Chapter 24). After speaking from both chairs

several times, Kabir concluded that the advantages of accepting the promotion outweighed the disadvantages. However, it was also apparent that Kabir felt very anxious about failing in this new post.

Session two: a corrective chairwork dialogue

The next session focused on restructuring the NATs associated with Kabir's anxiety ("I don't have enough experience to lead a team"). Unfortunately, dysfunctional thought records produced only a slight reduction in his anxiety. To stimulate further change, two-chair cognitive restructuring was employed (Chapter 18): Kabir first presented evidence supporting his NATs in chair one, followed by disconfirmatory evidence in chair two. When he became stuck, chairwork was paused so his therapist could guide him in formulating convincing counter-arguments. Kabir reported greater reductions in anxiety following this exercise.

5

Forms of perspective-taking

Adjusting one's perspective on events represents a common principle of change across cognitive-behavioural forms of psychotherapy (Mennin, Ellard, Fresco, & Gross, 2013). Therapists utilise a variety of techniques to facilitate this process including cognitive reframing, imagery, decentring, and, most recently, virtual reality (e.g. Osimo, Pizarro, Spanlang, & Slater, 2015). Chairwork provides a further means to transform perspective-taking.

Deictic framing

Relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001) provides a useful framework for understanding perspective-taking and perspective-changing in psychotherapy. According to RFT, perspective-taking is linked to symbolic, verbal-linguistic representations shaped by social interactions (Hayes et al., 2012). These representations, termed 'deictic frames', are defined as relational operant behaviours and form the building blocks of human experience (Neff & Tirch, 2013). Three key deictic frames are described in RFT: interpersonal perspectives ('I' versus 'you'), spatial perspectives ('here' versus 'there') and temporal perspectives ('now' versus 'then'). In the context of chairwork, we can also add intrapersonal perspective-taking ('I' versus 'me') and analogous perspective-taking ('as it is' versus 'as if it were') to this list. RFT suggests that by altering clients' deictic frames, psychological experience can be transformed (Villatte, Villatte, & Hayes, 2016).

Chairwork and perspective-taking

Cognitive behavioural chairwork brings about therapeutic effects partly by enabling individuals to explore and respond to distress through the lens of new, functional perspectives (Pugh & Rae, 2019). In fact, transforming perspective-taking represents one of the main ways cognitive behavioural chairwork is distinguished from gestalt and emotion-focused chairwork (which are principally concerned with the transformation of affect). Within the context of RFT, chairwork helps concretise these changes in deictic framing.

Five forms of perspective-taking are enabled through cognitive behavioural chairwork:

1. *Interpersonal perspective-taking* involves exploring experiences through interpersonal points of view.

Jane:	My friend said I was greedy for having dessert. I'm such a disgusting pig.
Therapist:	I wonder what your grandmother would say if she knew you were thinking this way. Change seats and be her voice. . . .

2. *Intrapersonal perspective-taking* involves responding to distressing experiences from adaptive, internal viewpoints.

Jane:	My friend said I was greedy for having dessert. I'm such a disgusting pig.
Therapist:	Let's respond to that thought from your compassionate side. Can you switch chairs and speak as that part of your self? . . .

3. *Temporal perspective-taking* involves exploring experiences from different points in time, such as from past and future points of view.

Jane:	My friend said I was greedy for having dessert. I'm such a disgusting pig.
Therapist:	Take a seat over there and be Jane-in-ten-years'-time. What would this version of your self think about what your friend said? . . .

4. *Spatial perspective-taking* involves exploring experiences from different spatial locations such as 'from above' and 'from a distance'. For example, metacognitive perspective-taking is operationalised in chairwork by asking the client to stand and survey how parts of the self (represented by different chairs) interact (see Chapter 9).

Jane:	My friend said I was greedy for having dessert. I'm such a disgusting pig.
Therapist:	Imagine placing those thoughts in this empty chair. Would it help if we moved that seat to the other side of the room? . . .

5. *Analogous perspective-taking* involves exploring experiences as if they were a different percept or object.

Jane:	My friend said I was greedy for having a dessert. I'm such a disgusting pig.
Therapist:	I can see how hurt you feel by her comment. If your sadness were held in this empty chair, what colour and shape would it be? . . .

6

Lights!

Self-multiplicity (principle I)

Chairwork is grounded in three overarching principles of implementation: self-multiplicity, personification and embodiment, and dialogue (Pugh, 2018). As this chapter and the following two chapters illustrate, these principles form the foundations of chairwork in CBT and other psychotherapeutic approaches.

Theories of self-multiplicity

Self-multiplicity refers to the notion that the self is composed of multiple, interacting 'parts' – a theoretical position which has been espoused in philosophical, psychological, and evolutionary fields for some time. Developmentally, these 'self-parts' are believed to emerge as ad hoc combinations of mental events (e.g. affects, cognitive processes, and sources of knowledge), which gradually become organised in response to early life events. Later, these basic states-of-mind cluster together to form distinct experiences of the self or 'self-states' (Siegel, 1999). Representations of others are also internalised over time, forming a communicative 'audience' for one's life (McCall, 1977).[1] From an evolutionary standpoint, these multiple experiences of the self play a crucial role in enabling humans to perform different social roles, each requiring particular social mentalities (Gilbert, 1989). Neuropsychology has lent support to theories of self-multiplicity, highlighting 'modular' experiences of the self associated with distinct patterns of brain activity (e.g. Klein & Gangi, 2010).

Theories of self-multiplicity have influenced psychotherapy (Rowan, 2012). Dialogical self-theory – a framework which bridges psychotherapeutic models and practices – suggests that psychopathology may stem from a restricted number of self-parts (monological experiences of the self), inflexible self-parts (rigid experiences of the self), disorganised self-parts (chaotic experiences of the self), or the dominance of distressing self-parts (tyrannical experiences of the self) (Dimaggio, Salvatore, & Catania, 2004). Self-multiplicity is also subject to power dynamics insofar self-parts may come to suppress, overbear, or support other parts (Hermans, 2004). Depression, for example, could be conceptualised as a monolithic experience of the self-as-worthless which is not counter-balanced by adaptive self-experiences (e.g. rational or compassionate parts of the self).

Self-multiplicity in CBT

As an information-processing model, CBT would seem to ascribe to a unitary model of selfhood. However, close examination of foundational texts reveals brief reference to multiple self-parts (see Beck, 1976; Beck et al., 1985). Later developments in cognitive science have led CBT to embrace self-multiplicity more explicitly, recognising that "we do not have one mind but many" (Teasdale, 1997, p. 70). Most recently, third-wave cognitive therapies have described a multifaceted conceptualisation of selfhood composed of functional and dysfunctional modes of experiencing (Young, Klosko, & Weishaar, 2003); rational, emotional, and wise mindsets (Linehan, 2015); critical, criticised, and compassionate selves (Gilbert, 2010); and transcendent states such as self-as-process and self-as-context (Hayes, Strosahl, & Wilson, 2012).

Theoretically, self-multiplicity has been understood in CBT as reflecting the differential activation of self-schemas: interrelated self-knowledge structures which form the basis of one's self-concept (Clark, 2016). Beck (1996) has expanded this schematic model of the self to include schematic 'modes': dynamic and autonomous subcomponents of personality containing cognitive, affective,

behavioural, and motivational substructures, which operate outside of conscious awareness and give rise to different experiences of the self. Similarly, Teasdale (1997) has described 'minds-in-place' which are 'wheeled-in' and 'wheeled-out' depending upon situational demands.

Whilst varying in emphasis, modern theories of cognitive science have acknowledged the existence of multiple, dynamic 'self-parts' (the term used to describe self-multiplicity henceforth), which guide cognitive, affective, and behavioural processes in functional or dysfunctional ways.

Implications for chairwork

Cognitive behavioural chairwork begins by identifying which of the client's self-parts will form the focus of intervention. Therapists also determine whether chairwork will address self-parts in their totality (e.g. the client's 'Critical Self') or their subcomponents (e.g. specific NATs, emotions, or behavioural motivations associated with self-criticism). In order to separate out these aspects of the client's experiencing, each self-part is placed in different chairs.

> Jane felt ashamed of her appearance. She linked this experience of her body to several NATs including "my tummy is too big" and "other people think I look ugly". Jane's therapist initiated chairwork by asking her to place her 'shaming side' in an empty chair (Therapist: "I'd like you to imagine that the part which makes you feel ashamed about your body is held in this seat").

Note

1. These points suggest that self-parts not only relate to experiences of the self, but also internalised representations of other individuals.

7

Camera!

Embodiment and personification (principle II)

Once self-parts have been placed in separate chairs, they are next imbued with a capacity to convey information (i.e. to speak) and receive information (i.e. to listen). Animating the client's internal world in this way helps establish the relative strength of self-parts, how they relate to one another, and whether these interactions mirror external relationships or autobiographical events (Gilbert & Irons, 2005). Externalising distressing internal experiences can also be transformational insofar as clients are able to interact with these events in a novel, social-relation manner. This not only enables more decentred reflective processing but also allows clients to apply skills from the external world to their intrapersonal experiences (e.g. using assertiveness to place boundaries on one's 'inner critic').[1] Most importantly, animation allows self-parts to engage in dialogical exchanges of information for the purposes of modification and integration (see Chapter 8).

Self-parts are 'brought to life' in chairwork in one of two ways: personification (conceptualising the self-part as a 'human-like' percept held in the empty chair) or embodiment (inviting the client to enact the self-part in a different chair).

Personification

Personification refers to the attribution of human characteristics to a non-human target. Whilst personification has sometimes been employed in CBT (e.g. Wagner, 2003), chairwork extends beyond

mere externalisation in two ways. First, any aspect of the clients' experience can be personified. This includes modes of information processing (e.g. the 'Critical Self'), cognitions (e.g. the 'mind-reading self'), emotions (e.g. the 'Anxious Self'), behaviours (e.g. the 'avoidant self'), and representations of others (e.g. the 'threatening-father'). Secondly, personifications are animated during chairwork and thus able to engage in meaningful, responsive interactions with the client (Therapist: "How do you imagine your anxious side responding when you offer it reassurance?").

Implications for chairwork

Personification invites the client to construe a self-part as something 'person-like' in the empty chair. Clients are asked to imagine salient features of these parts including their appearance (Therapist: "What does this [self-part/individual] look like?"), posture (Therapist: "How does it sit in the chair?"), expression (Therapist: "How does it look at you?"), and vocal quality (Therapist: "What tone of voice does it have?").

> Jane was asked to imagine what her 'shaming side' might look like if it were a person. She described a stern-looking older woman sitting in the seat opposite her.

Some internal experiences do not lend themselves to personification. Metaphorical imagery can be a helpful alternative. This involves the client visualising internal experiences in a multisensory but non-human form (see Chapter 19).

> Jane was asked to imagine what her feeling of shame would look like if it were held in the empty chair, including its size and colour. Jane described her shame as a dark swirling hole.

Embodiment

Theories of embodiment propose a bidirectional relationship between psychological processes and physiological states: whilst cognition influences the body and emotion through top-down processing, body-states can also influence cognitive and emotional processes via bottom-up processing (Tschacher & Pfammatter, 2016). Research supports these proposals, demonstrating that changes in body-states (e.g. posture and facial expression) influence emotion, cognitive appraisal, and behaviour (e.g. Wilkes, Kydd, Sagar, & Broadbent, 2017). Embodiment is also consistent with cognitive theories which describe directs link between somatic-kinaesthetic inputs and cognitive-affective representations (Teasdale & Barnard, 1993).

Within the context of chairwork, embodiment provides individuals with an immersive and evocative experience of their self-parts. By combining bottom-up and top-down modes of information processing, embodiment can also generate new experiences of the self which are authentic and anchored to physiological states (Bell, Montague, Elander, & Gilbert, under review; Chadwick, 2003). Finally, embodying self-parts may provide access to sources of information which might otherwise be unavailable (e.g. body-based memories or information encoded in motor forms) (Michalak, Burg, & Heidenrich, 2012).

Implications for chairwork

Embodiment invites the client to change seats and 'be' or 'speak as' an aspect of their self-experiencing. Simple instructions suffice when embodying familiar self-parts (Therapist: "Change seats and speak from the perspective of your critical side"). More guidance is needed when clients are asked to embody new experiences of the self (Therapist: "As the Compassionate Self, what posture would you adopt? What facial expression would capture a sense of non-judgemental concern? What pace and tone of voice would this caring side use? What does this part think and feel right now?").

> Jane's therapist asked her to change seats and 'speak as' her shaming side. Jane proceeded to voice her NATs in the second-person (Jane: "Everyone thinks you're ugly. Look at how fat your stomach is!").

Embodiment or personification?

When is personification or embodiment the preferred method during chairwork? Generally speaking, embodying self-parts tends to be more evocative than personification and usually stimulates greater cognitive-affective shifts. Accordingly, clients who struggle with emotional regulation or find particular self-parts highly distressing (e.g. hate-based forms of self-criticism) may prefer to use personification at first.

A note of caution: therapists should think carefully before asking clients to embody traumatising persons during chairwork. Adopting the viewpoint of these individuals invites empathy for their perspectives, which is usually counter-therapeutic (Kellogg, 2015). For examples of chairwork which involve the enactment of abusive persons, see historical role-play (Chapter 26) and forgiving others (Chapter 27).

Note

1. Relating therapy (Hayward et al., 2009) exemplifies how interpersonal skills (e.g. assertiveness) can be applied to distressing interpersonal events (i.e. voice-hearing) through role-play.

8

Action!

Dialogue (principle III)

If the personification and embodiment of self-parts represents the means of chairwork, dialogue between these perspectives represents its end (Rowan, 2012). Often, it is only through an exchange of information – a dialogue – between parts of the self during chairwork that adjustments in thought, feeling, and behaviour will occur.

From a theoretical perspective, cognitive and emotional process have often been conceptualised as dialogical events (Colapietro, 1989, cited, in Wiley, 2006). These forms of intrapersonal communication are believed to originate from internalised interactions between infant and caregiver (Fogel, de Koeyer, Bellagamba, & Bell, 2002). Social mentality theory (Gilbert, 1989) suggests that intrapersonal dialogue may also have a basis in evolution, insofar as patterns of thought, feeling, and behaviour developed for regulating social relationships can also be enacted at an internal level in humans.

Echoing these sentiments, CT texts have often described cognition using dialogical terms such as ‘self-statements’ and ‘internal speech’ (Beck, 1976). Meichenbaum (1977) underscores the dialogical nature of thought, describing cognition as a “self-communication system, a dialogue with oneself, that comes to influence behaviour” (p. 212). Emotion has also been described as dialogical, insofar as affect communicates important information regarding personal needs, behavioural motivations, and cognitive meanings (Beck, 1976; Fridja, 1986). In short, functional emotions ‘tell us’ something important.

Dialogical conceptualisations of thought and feeling also confer psychotherapeutic benefits. Firstly, ‘speaking to’ one’s

distressing thoughts and feelings is considerably more evocative than merely 'speaking about' these experiences, thus enabling more productive cognitive-affective modification (see Chapter 10). Secondly, speaking from the perspective of self-parts promotes ownership of these experiences: when individuals enact distressing intrapersonal events through chairwork (e.g. self-criticism), they recognise these processes are said and done to oneself (e.g. *self-to-self*-criticism) (Greenberg, Safran, & Rice, 1989). Thirdly, speaking from the perspective of dysfunctional thoughts and feelings allows therapists to assess both the content and the tone of these experiences. In doing so, parallels with other (external) voices are established (Therapist: "Did speaking as your inner critic remind you of anyone in your life?"). Finally, dialogue by its very nature assumes a plurality of perspectives (Perls, 1969), thus challenging singular explanations and responses to events (Therapist: "Although you believe this negative thought a great deal, does any part of you view this situation differently? Can you change seats and speak from that perspective?").

Implications for chairwork

Once parts of the self have been differentiated (through their placement in separate chairs) and activated (through either personification or embodiment), transformative exchanges of communication between self-parts can take place.

> Jane returned to her original chair after enacting her shaming side. Upon reflection, she noted the similarities between the 'voice' of her shaming side and the 'voice' of her critical mother. With encouragement, Jane then practised responding assertively to her shaming self-part from the perspective of her 'rational' self-part.

9

Process skills

Whilst the aforementioned principles represent the foundations of chairwork, they do not stimulate cognitive-affective change in isolation. Process skills refer to the moment-by-moment interventions clinicians use to ensure chairwork achieves its therapeutic goals. Simply put: if self-multiplicity, personification, embodiment, and dialogue represent the building blocks of chairwork, process skills are its mortar.

Clarity

When embodying self-parts, clients are encouraged to speak clearly and forcefully from each perspective. Concurrently, therapists must ensure that the 'voice' of each self-part remains distinctive during the dialogue (Kellogg, 2015).

Therapist: Now that we've heard from your NAT, I'd like you to change seats and respond from the perspective of your rational side. Leave the NAT in your first chair and speak only as your rational voice in this seat. . . .

De-roling (or 'palate cleansing')

When clients move between chairs, it is sometimes helpful to spend a little time detaching from the self-part which has just spoken. This process of 'palate cleansing' helps shake-off overlearned or

dysfunctional self-parts before moving into new perspectives, as well as grounding the individual during changes in role (Paul Gilbert, personal communication).

Therapist: Before moving into your 'rational self', let's take a moment to step out of your 'Critical Self'. Stand-up, stretch, perhaps walk around the chair. . . . Now switch seats and adopt the perspective of your 'rational self'. . . .

Embodiment

Embodiment is enhanced by identifying and adopting salient features of a self-part prior to speaking from that perspective (e.g. its posture, expression, and tone) (Kolt, 2016). These 'stage directions' help clients immerse themselves in these new, embodied points of view and differentiate patterns of cognitive-affective self-experiencing (Bell et al., in review).

Therapist: Change into the seat of your 'Compassionate Self'. . . . Before speaking from this perspective, try taking on the posture of this self – strong and upright. . . . Adopting an expression of care and concern. . . . Bringing to mind the motivation to relieve the suffering of yourself and others. . . . Do you feel better connected with the compassionate side now? . . .

Expressing needs

Inviting the client to express their emotional needs during chairwork builds affect and affirms these needs are important and legitimate

(Greenberg, Rice, & Elliott., 1993). Indeed, research suggests that expressing one's needs in reaction to distressing self-parts can help transform associated patterns of dysfunctional thought and feeling (Elliott, Watson, Goldman, & Greenberg, 2004).

Therapist:	Tell the worrying side of your self what you need from it. [*Gestures to the chair holding the 'worrying side'*].
Client:	[*To the empty chair*]. I need you to stop scaring me all the time. It's not helpful. . . .

Feeding lines

Therapists sometimes offer the client empathically-informed statements to repeat aloud during chairwork (Greenberg, 1979; Kellogg, 2015). 'Feeding lines' serves multiple functions: evocative lines heighten emotion; reflective statements illuminate information at the edges of awareness; summary statements clarify clients' current experiencing. When offering lines, these are framed as invitations rather than directives (Therapist: "If it fits with your experience, try saying. . . ."). Statements of recognition (Therapist: "It hurts when the critical side attacks you") tend to be more productive than questions (Therapist: "Does it hurt when the critical side attacks you?") (Greenberg et al., 1993).

Client:	[*To their 'child self', held in an empty chair*]. It's ok to make mistakes. You're just a child.
Therapist:	Perhaps try saying, "You're such a good girl and you try so hard. Making mistakes doesn't change that". . . .

Guiding attention

Clients sometimes switch perspectives whilst enacting a self-part. Equally, clients may begin speaking to the therapist rather than the 'other' during empty-chair dialogues. If this occurs, clients are encouraged to either maintain the perspective they are embodying (during internal dialogues) or to refocus their attention on the 'other' (during external dialogues). When other perspectives repeatedly push to be heard, the client is asked to change seats and give voice to that self-part (Kellogg, 2015).

Client:	[*To an abusive parent, held in the empty chair*]. You had no right to hurt me when I was a child. [*Turning to therapist*]. I would never treat my daughter that way.
Therapist:	Say that to your mother. [*Gestures to the empty chair*]. "I would never treat a child the way you treated me". . . .

Imagery

Imagery plays a crucial role in personification and empty-chair dialogues. In both cases, the client is asked to visualise salient features of the 'other' (e.g. their posture, gesture, and facial expression) before the dialogue starts (Greenberg et al., 1993).

Therapist:	Imagine your critical father were sat in that chair. [*Gestures to an empty seat*]. How do you see him? What is he wearing? How does he look at you? . . .

Language

Therapists utilise evocative language to heighten emotion and access ‘hot’ cognitive material during chairwork.

Client: [*Speaking as the ‘inner critic’*]. Look at your body! It’s an embarrassment!
Therapist: [*Intensifying emotion*]. What else does this side say to make you feel *ashamed* of your appearance? How else does it *attack* the way you look? . . .

Equally, summaries and lines offered by the therapist which incorporate neutral language can help down-regulate intense emotions.

Movement and separation

Movement between chairs separates and concretises different experiences of the self. Switching positions also helps clients distance themselves from the self-parts which have just spoken. When additional self-parts are incorporated into chairwork, extra chairs are introduced.

Client: [*Speaking as the ‘Anxious Self’*]. I’m really scared my boyfriend won’t call because of the fight we had. It annoys me how unreasonable he is.
Therapist: It sounds like your ‘Angry Self’ is coming out now. If ‘Anxious Self’ has nothing to add, can you change seats and be the angry side? . . .

Non-verbal communication

CBT assumes a reciprocal relationship between cognition, emotion, biology, and behaviour. Accordingly, prompting the client to put words to their non-verbal behaviour/communication during chair-work elicits valuable information regarding their current thoughts and feelings (Greenberg, 1979; Perls, 1969). Changes in the client's non-verbal behaviour may also signal the emergence of 'hot' cognitive material (Safran & Greenberg, 1982).

Therapist: I notice you clenching your fist as you speak to your father. What's your clenched fist saying? How does it relate to what you're thinking right now? . . .

Ownership

Clients are encouraged to speak in the first-person when enacting healthy self-parts to promote ownership of these experiences.

Client: [*To a NAT*]. But that isn't true! It would be unreasonable to never, ever make mistakes.
Therapist: Try saying to the NAT, "*I* don't think it's reasonable that *I* never make mistakes. *I* think mistakes are acceptable. . . .

In contrast, second-person language is normally used when enacting maladaptive self-parts to help externalise these dysfunctional perspectives.

Posture and gesture

Adjusting clients' posture and gesture during chairwork can stimulate cognitive and emotional change. Inviting the client to stand can be especially empowering (Kellogg, 2015).

Client:	[*To a workplace manager, represented by an empty chair*]. I work hard and I deserve a pay rise.
Therapist:	See how it feels saying that from a standing position. Make your case for a raise again, but this time stand with your shoulders square and back straight. . . .

Asking the client to exaggerate their postures and gestures during chairwork can also establish kinaesthetic anchors to particular experiences of the self (Bell et al., in review).

Praise

Therapists use praise to encourage clients during chairwork, such as in response to important or transformative statements (Kellogg, 2015).

Client:	[*To a NAT*]. What you're saying isn't true. In fact, you're not worth listening to.
Therapist:	Good. Tell that thought why it's not helpful. . . .

Repetition

Asking the client to repeat important statements during chairwork amplifies emotion, reinforces transformative statements, and builds conviction in new appraisals (Greenberg, 1979; Perls, 1969).

Client:	[*To an abusive parent*]. It was wrong what you did to me as a child.
Therapist:	Say that to him again. . . .

Simplification

Simple statements which distil key messages are most effective when summarising or feeding lines to the client. Indeed, the length of therapist utterances is often inversely proportional to their impact (Neimeyer, 2012).

Client:	[*Embodying the 'sad self'*]. It's so hard getting through the day. Everything feels so hopeless.
Therapist:	It's like, "I just want to give up". . . .

Specificity

Delineating the specifics in what self-parts say helps to amplify affect and bring detail to the dialogue (Greenberg, 1979). For example, Critical Self-parts can be asked to be more definitive in their attacks.

Client:	[*Speaking as a negative core belief*]. You're a failure.
Therapist:	Be specific. Tell her the ways in which she's failed. [*Gestures to the client's former chair*]. . . .

Equally, conviction in positive appraisals is enhanced by encouraging the client to be more precise when challenging negative

self-parts (Therapist: "Tell that NAT the *specific ways* in which it's untrue").

Speech and tone

Increasing clients' speed and tone of voice builds energy and momentum during chairwork (Kellogg, 2015). Equally, slowing down clients' rate of speech encourages greater contact with and processing of emotions.

Client:	[*To the 'inner critic'*]. I need you to stop putting me down.
Therapist:	Say that again, but slower and louder this time. . . .

Therapist intervention

Therapists sometimes intervene on behalf of the client during chairwork (Arntz & Jacob, 2013). Used appropriately, speaking for the client can be a therapeutic experience, such as when individuals struggle to defend themselves against destructive self-parts or abusive individuals. Therapists will usually seek permission before intervening.

Client:	The critical side is saying I'm a complete waste of space. [*Gestures to the empty chair*].
Therapist:	Can I say something to that part? [*Client nods*]. Thank you. [*Turning to the empty chair*]. Stop being a bully! Go away if you have nothing helpful to say. . . .

10

Mechanisms I – information processing

CBT integrates insights from cognitive and behavioural sciences to formulate theory-driven interventions and clarify their mechanisms of action (Salkovskis, 2002). As the next five chapters illustrate, theoretical perspectives also provide insights into how and why cognitive behavioural chairwork achieves therapeutic effects.

Theories of multi-level information processing

The theory of interacting cognitive subsystems (ICS) (Teasdale & Barnard, 1993) is a multi-level model of information processing which identifies two key levels of meaning. The first is a propositional code which is concerned with specific, verifiable, language-correspondent meanings. Information processing at this level is equated with intellectual belief or 'knowing with one's head' (e.g. "I *know* many of my clients experience symptomatic improvements"). The second level of meaning relates to an implicational code concerned with global, holistic forms of knowledge. The higher-order, schematic meanings at this level do not readily map onto language and are usually experienced as implicit 'felt senses' ("I nonetheless *feel* ineffective as a therapist") (Teasdale, 1997). Accordingly, implicational knowledge is often associated with emotional beliefs or 'knowing with one's heart'. Unlike the propositional subsystem, the implicational code shares direct links with emotion and multisensory inputs including visual, auditory, and kinaesthetic data.

ICS provides a parsimonious account of why 'head-level' belief change does not always translate into 'heart-level' change in CBT; a 'rational-emotional dissociation' which many therapists will be

familiar with (Stott, 2007). To avoid this 'head-heart lag', ICS suggests that implicational change should form the focus of CBT. Working at this level of meaning necessitates specific methods of intervention, however. Psychoeducation or 'cold' examination of one's thoughts, for example, risks focusing on propositional knowledge without engaging affective processes, thus limiting cognitive-affective change. Instead, multisensory interventions which impact upon all schematic dimensions (thoughts, memories, feelings, body-states, and behaviour) are likely to bring about implicational change more effectively. In addition, modifying the implicational code may require "actual experiences in which new or modified models are created" (Teasdale, 1997, p. 90).

Implications for chairwork

It is hypothesised that the therapeutic effects of chairwork partly relate to the impact these techniques have upon implicational knowledge (Samoilov & Goldfried, 2000; Pugh, 2017). Indeed, Teasdale (1997) suggests that "enactive procedures, [occurring] either in reality or imagination" (p. 90), may be a particularly effective means to modify the implicational code. Supporting this proposal, early research suggests chairwork can generate greater cognitive-affective change than verbal (propositional) interventions (de Oliveira et al., 2012).

Which processes enable chairwork to modify implicational knowledge? First, chairwork utilises multisensory inputs (sights, sounds, and bodily feedback) which are directly linked to implicational knowledge. As Corsini (2017) notes, "in acting out a problem one acts, feels, and thinks at the same instant . . . the patient operates holistically, not partially" (p. 12). Consistent with this proposal, research has linked outcomes in emotion-focused chairwork to changes in specific sensory channels (i.e. the client's tone of voice) (Greenberg, 1983). Second, chair-based techniques usually generate higher levels of emotion than discussion and reasoning. Affective arousal, which shares links with the implicational code, may provide chairwork with another 'window' to implicational knowledge

(Samoilov & Goldfried, 2000). Third, chairwork makes use of the body (e.g. movement and posture), thus providing a final means of accessing the implicational code. Research which links enhanced outcomes in chairwork to movement between seats would support this point (Delavechia, Velasquez, Duran, Matsumoto, & de Oliveira, 2016).

11

Mechanisms II – emotion

Although emotion plays a crucial role in cognitive modification, CBT has sometimes been accused of viewing affect as somewhat troublesome (Wiser & Goldfried, 1993). With a few exceptions (e.g. exposure and response prevention), many cognitive-behavioural interventions would appear to focus on containing – rather than eliciting and processing – emotion. In contrast, experiential psychotherapies regard emotional experiencing as vital to therapeutic change (Greenberg, Rice, & Elliott, 1993).

The role of emotional processes has been increasingly recognised in CBT. Theoretically, the arousal, processing, and expression of affect is believed to enable cognitive-behavioural change via multiple routes including the activation of affect-laden cognitions, encouraging assimilation of new learning, and promoting habituation (Hunt, Schloss, Moonat, Poulos, & Wieland, 2007; Safran & Greenberg, 1982). Supporting these points, studies have linked outcomes in CBT to several in-session affective processes including clients' level of emotional expression, experiencing, and exploration (e.g. Coombs, Coleman, & Jones, 2002).

Emotional processing theory (EPT; Rachman, 1980; Foa et al., 2006) further elucidates the role of emotion in CBT. According to EPT, distress arises from maladaptive emotional 'structures' which comprise associations between stimuli, responses, and distorted meaning representations. These structures persist over time due to a variety of factors including avoidance and distorted evaluations regarding intolerability ("I will be overwhelmed by distress") and probability ("every experience of emotional distress will be intolerable"). In order to modify these pathological structures, emotional processing must take place under two conditions: (1) activation of the emotional structure ('arousal') combined with (2) presentation

of disconfirmatory information which is incorporated into existing knowledge ('new learning'). Viewed within this framework, exposure is believed to ameliorate distress by arousing emotion alongside the provision of corrective information, whilst subsequent habituation provides further disconfirmatory evidence ("My emotions did not overwhelm me and so escape is unnecessary").

Implications for chairwork

As an evocative technique, chairwork provides a medium for eliciting, expressing, and ameliorating distressing emotions and associated affect-laden cognitions. For these reasons, therapists aim to raise affect to a level which is high but tolerable during chairwork. Reconstructing distressing intrapersonal events (e.g. self-criticism) and distressing interpersonal experiences (e.g. criticism by others) through enactment is a particularly effective way to access this 'hot' cognitive material (Arntz & Weertman, 1999; Padesky, 1994).

Chairwork also enables emotional processing. In addition to facilitating exposure to distressing intrapersonal and interpersonal events, recreating these experiences provides clients with corrective information regarding their tolerability and dangerousness. By proposing chairwork, therapists also communicate that these events are not so overwhelming as to necessitate avoidance (Chadwick, 2003). Lastly, clinicians may find it difficult to activate certain emotional structures in therapy. Childhood emotional abuse, for example, may lead to diffuse or situationally-accessible emotion structures (Brewin, 1989). Used responsibly, chairwork provides a method for recreating these experiences in therapy to help bring underlying emotional structures 'online' and render them modifiable. Supporting the role of emotional processing in chairwork, techniques such as 'dialogical exposure' and 'imaginal confrontation' have proved to be effective exposure-based interventions for resolving traumatic events (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Butollo, Karl, Konig, & Rosner, 2016).

12

Mechanisms III – imagery

Theories of information processing and emotional processing converge on the idea that affect plays an important role in chairwork. Imagery is also believed to share a close relationship with emotion (Hackmann, Bennett-Levy, & Holmes, 2011). Mental images arise when perceptual information is retrieved from memory or modified to produce novel representations (Kosslyn, Ganis, & Thompson, 2001). Imagery also extends beyond just the visual and can incorporate other sensory details including sounds and somatic data. Consistent with the assertion that emotional material is most readily retrieved in pictorial rather than linguistic forms, research indicates that imagery has a greater impact upon emotional states than verbal processes (Hackmann et al., 2011).

Holmes and Mathews (2010) have presented three hypotheses regarding the relationship between imagery and emotion. First, mental images are believed to activate basic brain systems underlying emotion more directly than language, which developed later in human evolution. Second, mental imagery often draws upon autobiographical information and so can reinstate similar feelings to those experienced during past events. Third, neuro-imaging studies highlight an overlap in the patterns of brain activity associated with imagery and actual perception, suggesting that mental images are experienced in a similar way to visual percepts.

Implications for chairwork

Just as images are closely related to emotion, chairwork shares a special bond with imagery and affect. Indeed, clinicians have noted the similarities between imagery techniques and the enactive

methods employed by Moreno and Perls (Hackmann et al., 2011). Such is the overlap, chairwork and imagery have sometimes been described in interchangeable ways ('imagery psychodrama').

Evolutionary theories of imagery provide an explanation as to why chairwork generates more intense affect than discussion. When clients 'speak to' their problems through chairwork, visual and symbolic representations are combined, thus stimulating the basic brain structures underlying emotion. In contrast, 'speaking about' these issues relies solely on linguistic processes which have an indirect link to emotion.

Perceptual theories of imagery suggest that visualisation also amplifies affect during chairwork. External dialogues, for example, begin by picturing the 'other' in the empty chair, thus stimulating clients' affective reactions to these persons. Equally, mental images of self-parts will often arise spontaneously during internal dialogues (Tobyn Bell, personal communication). In either case, it would appear that individuals interact with representations of the self and others as real percepts during chairwork.

Lastly, memory-based theories of imagery are relevant to autobiographical chairwork techniques such as historical role-play (Chapter 22) and unfinished business (Chapter 28). When individuals from the past are imagined in the empty chair, associated episodic memories associated are activated. When clients go on to speak to these individuals in therapeutic ways (e.g. challenging a neglectful caregiver), the dysfunctional meanings encapsulated by these memories are subsequently updated (Lane, Ryan, Nadel, & Greenberg, 2015).

In summary, mental imagery plays an important role in chairwork for several reasons. First, dialogical techniques incorporate both language and visualisation, thus providing a direct link to emotional centres of the brain. Second, mental images prompt individuals to interact with representations of the self and others as true percepts, thereby deepening immersion and stimulating affective arousal. Third, autobiographical chairwork techniques will elicit emotive episodic memories, thus allowing their meanings to be adjusted. These points suggest that chairwork may offer a viable

alternative to certain imagery techniques (e.g. imaginal exposure and imagery rescripting).

Finally, it should be noted that whilst imagery augments chair-work, the reverse is equally true: chairwork also allows clients to speak to and from the perspective of distressing images in order to clarify and transform their underlying meanings (Edwards, 1989; Perls, 1969).

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Mechanisms IV – retrieval competition

Change processes in CBT have been hotly debated. Whilst accommodation models argue that psychological treatments modify the schematic structures underlying distress (see Chapter 10), constructivist accounts propose that psychotherapies establish new, adaptive representations which leave these original knowledge structures intact (Brewin, 2015). These latter frameworks have stressed the importance of generating, reinforcing, and improving access to alternate positive schematic representations during CBT (Ingram & Hollon, 1986).

One such constructivist framework, the theory of retrieval competition (TRC) suggests that representations in working memory compete for retrieval (Brewin, 2006). In psychological disorders, highly sensitised, negative representations are believed to possess a 'retrieval advantage' over their adaptive counterparts which are comparatively underdeveloped or absent. The aim of CBT, therefore, is to enhance the accessibility of positive memory representations, such that they maintain a competitive advantage. Factors which are believed to increase the preferential retrieval of positive representations include the memorability, distinctiveness, positive valence, and rehearsal of these alternative schematic models.

Brewin (2006) suggests that various interventions can be used to construct and enhance the retrievability of adaptive representations. Exposure, for example, is believed to establish adaptive memory representations which inhibit prior learning, whilst cognitive restructuring elaborates and reinforces these positive representations. It should also be noted that these positive representations do not need to be grounded in logic or reality. Rather, they need only be sufficiently distinctive and memorable to successfully win out for retrieval. This explains why interventions incorporating fantasy and imagination generate therapeutic effects (e.g. imagery rescripting).

Implications for chairwork

Retrieval competition suggests that adaptive representations – and perhaps the interventions used to construct them – must be sufficiently memorable and distinctive to out-compete maladaptive representations. Consistent with this theory, several studies suggest that chairwork is a particularly memorable psychotherapeutic procedure (Chadwick, 2003; Robinson, McCague, & Whissell, 2014). What makes chairwork so impressive? First, enacting distressing intrapersonal and interpersonal events is a poignant experience for many individuals (Greenberg, 1979). Indeed, Brewin (2006) suggests that the valence of adaptive representations developed through cognitive reappraisal might be enhanced by introducing a novel, interpersonal dimension to these interventions (e.g. telling one's 'inner critic' that it is unhelpful). Second, research suggests that emotive and multisensory representations are most likely to persist in memory (Laney, Campbell, Heuer, & Reisberg, 2004). Finally, the representations constructed through immersive procedures such as chairwork may be especially advantageous due to their multimodal activating cues.

14

Mechanisms V – other processes

Decentring

Decentring describes the metacognitive ability to 'step back' and observe mental events from a psychological distance. Decentring plays a critical role in cognitive restructuring and emotional regulation insofar as managing internal experiences requires an ability to distance oneself from these (Beck, 1976; Naragon-Gainey & DeMarree, 2017). Supporting these points, numerous studies highlight the benefits of cultivating a decentred relationship with mental events including improved perspective-taking, distress tolerance, and self-acceptance (Hölzel et al., 2011).

Most chairwork techniques encourage decentring, albeit indirectly. For example, enacting one's distressing thoughts and feelings in a second chair provides opportunities to practice 'stepping into' and 'stepping back from' these experiences. External dialogues involving significant others also encourages decentring through a '3-2-1-3' sequence of speaking (Rowan, 2012): first, the 'other' is discussed in the third-person (Therapist: "How did your mother criticise you as a child?"), then embodied in the second-person (Therapist: "Change seats and speak as your critical mother"), then confronted in the first-person ("Change back and respond assertively to what your mother has said") and lastly observed from a third-person perspective ("From a standing position, what do you make of this new style of interaction between your self and your mother [*gestures to the empty chairs*]?").

Other chair-based methods facilitate decentring more directly. Asking the client to stand and survey how parts of the self interact

during chairwork creates literal and metaphorical metacognitive distance from these experiences. Personification (Chapter 7) similarly encourages decentring: by placing a distressing material outside of oneself (i.e. in the empty chair), an observing perspective on these experiences is established.

Attention

Adaptive functioning requires the ability to focus, sustain, and shift attention according to environmental demands. Research has linked emotional disorders to maladaptive attentional processes including biases towards threatening information and difficulties disengaging from negative stimuli (Mennin, Ellard, Fresco, & Gross, 2013). Based upon these observations, the self-regulatory executive function model (S-REF; Wells & Matthews, 1994) proposes that psychopathology is maintained not only by the contents of thought, but perseverative thinking styles characterised by excessive self-focused attention and threat monitoring (e.g. rumination and worry). Accordingly, S-REF has promoted the development of interventions which aim to improve attentional control and disrupt repetitive cognition (e.g. attention training treatment; Wells, 1990).

Like attention training, two-chair techniques encourage purposeful redeployments in attention through movement between chairs (Pugh, 2017). Other chair-based techniques help strengthen attention towards adaptive representations. For example, if distressing thoughts intrude upon work involving the consolidation of positive core beliefs, clients can be asked to place these cognitions in an empty chair and refocus on the exercise (Therapist: “Let’s place those negative thoughts over there and bring our attention back to finding evidence in support of your positive core belief”). Used in this way, chairwork strengthens the retrieval of positive data whilst inhibiting passive ‘mind wandering’ towards negative content (Smallwood & Schooler, 2006).

Experiential learning

Behaviour training programmes which incorporate chair-based techniques such as modelling and role-play have proven highly effective (see Chapter 20). Theories of learning explain why experiential methods such as chairwork can enhance skills acquisition. For example, Kolb's (1984) experiential learning cycle highlights the importance of developing and refining skills through direct experience. Similarly, social learning theory (Bandura, 1969) proposes that observation and rehearsal play an important role in adopting and reinforcing new behaviours. Taken together, these theories suggest that action-based methods such as chairwork enable behaviour change through experiential learning. These principles also apply to therapist training and supervision (see Chapter 29).

Embodied cognition

Before concluding this chapter, it is worth returning to embodiment theory. Embodiment describes the reciprocal relationship between bodily states and psychological processes. Whilst Chapter 7 has described some of the ways embodiment is used to facilitate chairwork, theories of embodied cognition suggest that the enactment of self-parts may in itself stimulate cognitive and emotional change. Indeed, experimental research has found that adjustments in posture improve mood (e.g. Wilkes, Kydd, Sagar, & Broadbent, 2017), whilst embodying new points of view through virtual reality can enhance reasoning skills (e.g. Osimo, Pizarro, Spanlang, & Slater, 2015). This suggests that chairwork achieves therapeutic effects not only via dialogical processes but also through the embodiment of new, adaptive experiences of the self.

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Evidence base

Although many cognitive behavioural therapies incorporate chair-work, this does not provide direct or substantive empirical support for these techniques. Unfortunately, chairwork is yet to undergo the same rigorous evaluation as other experiential methods (e.g. imagery). Nonetheless, sufficient evidence exists to hypothesise that chairwork is an effective form of intervention. This chapter provides a selective review of chairwork-related studies.

Direct evidence

Direct evidence relates to studies which have evaluated chairwork techniques developed within cognitive-behavioural frameworks. Quantitative studies suggest that cognition-focused forms of chairwork achieve positive outcomes. For example, 'trial-based role-plays' (see Chapter 22) have been shown to reduce the severity of negative self-beliefs, self-criticism, and associated distress (de Oliveira, 2008). Technique comparison studies suggest chairwork might also be advantageous compared to some 'standard' cognitive interventions. For example, de Oliveira and colleagues (2012) found that trial-based role-plays were more effective than automatic thought records and positive data logging in reducing fears of negative evaluation, social avoidance, and life impairment in a socially phobic sample. In another study, imaginal confrontation of antagonists through role-play was found to perform better than Socratic discussion in reducing anger and aggressive behaviour (Bohart, 1977).

In the behavioural domain, numerous studies indicate that role-play is an effective means to develop new behavioural skills (e.g.

Speed, Goldstein, & Goldfried, 2017) and is considerably more effective than instruction (Lazarus, 1966) (see Chapter 20). However, other research suggests that role-play plus cognitive restructuring may be the most effective form of skills training (Linehan, Goldfried, & Goldfried, 1979). Similar findings have been reported in the context of clinical supervision insofar as experiential procedures (i.e. role-play) improve therapist competence and fidelity to a greater degree than discussion alone (e.g. Cross et al., 2011) (see Chapter 29).

Finally, two qualitative papers have explored subjective experiences of chairwork in CBT and CFT (Bell et al., in review; Chadwick, 2006). Both studies draw attention to the realism, memorability, and emotional intensity of these techniques. Participants described chairwork as transformative insofar as it generated powerful changes in thought, feeling, and insight – sometimes to a greater degree than other talk-based techniques (e.g. cognitive restructuring). The value of decentring through enactment is also highlighted in both studies. Similar findings have been reported in research examining emotion-focused forms of chairwork (Robinson, McCague, & Whissell, 2014; Stiegler, Binder, Hjeltnes, Stige, & Schanche, 2018).

Indirect evidence

Indirect evidence relates to research which explored the effectiveness of chairwork techniques developed outside of CBT. Several studies have evaluated emotion-focused forms of chairwork, which has sometimes been combined with 'standard' CBT (e.g. Newman et al., 2011) (see Chapter 27). For example, two-chair techniques for self-evaluative splits (i.e. self-criticism) have been shown to improve depression, anxiety, and self-compassion (Greenberg & Dompierre, 1981; Neff, Kirkpatrick, & Rude, 2007). Empty-chair techniques have also proved effective in resolving lingering feelings towards others and reducing interpersonal distress (Paivio & Greenberg, 1995). Furthermore, studies suggest that emotion-focused chairwork ameliorates distress to a greater degree than other

affect-orientated techniques (e.g. emotional focusing) (Greenberg & Dompierre, 1981).

Dismantling studies provide additional support for emotion-focused chairwork. To determine whether the active techniques utilised in EFT (which include chairwork) improve upon the therapeutic effects of the client-centred relationship, two randomised controlled trials compared EFT against person-centred therapy in the treatment of depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). EFT was found to perform better on all outcome measures. Similarly, Paivio, Jarry, Chagigiorgis, Hall, and Ralston (2010) compared two versions of EFT for trauma which either did or did not incorporate the imaginal confrontation of past abusers through chairwork. Whilst both treatments were effective, clients who engaged in imaginal confrontation were more reliably improved at the end of treatment. Whilst these studies provide support for emotion-focused chairwork, it is uncertain whether these results are entirely attributable to chairwork alone.

Other research has compared 'standard' CBT against CBT combined with chair-based techniques developed within experiential psychotherapies. Regarding depression, Holtforth and colleagues (2017) compared CBT and exposure-based cognitive therapy (EBCT), the latter incorporating additional interventions for enhanced emotional processing (including emotion-focused chairwork). Both therapies were found to be equally effective. Equivalent outcomes are also reported by Hamamci (2006), who compared group CBT against group CBT plus psychodrama role-plays. In generalised anxiety, Newman and colleagues (2011) tested the effectiveness of CBT plus interpersonal and emotion-processing tasks (which included emotion-focused chairwork) against CBT combined with supportive listening. Whilst both treatments produced equivalent improvements, CBT plus chairwork was favoured across most outcome measures. More recently, Butollo, Karl, Konig, and Rosner (2016) randomised individuals diagnosed with PTSD to either a cognitive behavioural treatment or an integrative therapy which incorporated elements of CBT and gestalt empty-chairwork ('dialogical exposure therapy'). Whilst effect sizes favoured the

cognitive-behavioural intervention at the end of treatment, remission rates were equivalent at follow-up. Interestingly, the therapy incorporating gestalt chairwork was found to be advantageous in terms of improved interpersonal functioning at follow-up, whilst the cognitive behavioural treatment produced greater improvements in trauma-related cognitions.

Finally, several studies have compared chairwork techniques developed outside of CBT against cognitive-behavioural interventions. For example, Karst and Trexler (1970) compared a brief, three-session fixed role-play intervention against a rational-emotive intervention. Fixed role-play was found to be more effective than RET in reducing social anxiety, although no other between-treatment differences were found. In a later study, single-session gestalt empty-chairwork and cognitive restructuring produced equivalent reductions in problematic anger (Conoley, Conoley, McConnell, & Kimzey, 1983). Similar results are reported by Johnson and Smith (1997), wherein gestalt empty-chairwork performed as well as systematic desensitisation in treating snake phobia. Within the context of ambivalence, Clarke and Greenberg (1986) found that two-chair techniques were more effective than problem-solving in encouraging decision-making (see Chapter 24). The same two-chair technique was later compared against a different cognitive intervention (cost-benefits listing) but was not found to be advantageous (Trachsel, Ferrari, & Holtforth, 2012).

Implications for chairwork

Whilst cognitive behavioural chairwork has produced promising results, many cognition-focused interventions are yet to be evaluated. Support for chairwork appears strongest within the domain of behaviour skills training. Considerably more research has examined chairwork techniques developed in experiential psychotherapies, most notably EFT. Not only do these techniques appear to be clinically effective, but recent studies suggest these forms of chairwork can be successfully integrated into CBT. Finally, technique

comparison studies indicate that chair-based techniques developed within experiential psychotherapies perform as well as some cognitive interventions and may be advantageous in certain circumstances. Additional outcome studies are now needed to confirm the effectiveness of cognitive behavioural chairwork. In addition, task-analytic research would help clarify the active ingredients of these methods.

Part II

PRACTICAL APPLICATIONS OF COGNITIVE BEHAVIOURAL CHAIRWORK

Introduction to Part II

Part II explores the practical applications of chairwork in CBT and allied therapies. Readers are encouraged to view the following interventions as descriptive rather than prescriptive: chairwork is a creative method and therapists should be inventive in how they apply these techniques.

Chairwork techniques are illustrated throughout using the therapy transcripts of two fictitious individuals introduced during earlier chapters: Jane and Kabir.

Jane

Jane is a student in her mid-twenties. She has started CBT for her eating disorder (anorexia nervosa, binge-purging subtype). Jane's eating difficulties stem from overvalued beliefs about shape and

weight ("If I am thin, I am more acceptable to others"), difficulties managing emotions ("If I restrict, I feel less emotional pain"), and low self-esteem ("I am worthless"). She feels ambivalent about recovering from her eating disorder.

Kabir

Kabir is a father in his mid-forties. He has started CBT for depression, alcohol misuse, and longstanding social phobia. He is working towards abstinence. Kabir's depression was precipitated by the breakdown of his marriage due to his alcoholism. Kabir's low mood and social anxiety are grounded in core beliefs relating to incompetency and unacceptability ("I am unlikeable and a failure").

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Applying chairwork in CBT

Practical considerations

Timing

Chairwork will often take up a substantial proportion of the therapy session. A 'rule of thirds' can help manage time: one-third of the session is dedicated to agenda-setting, homework review and preparation for chairwork; one-third for implementing chairwork; and one-third for reflection and debriefing.

Number and arrangement of chairs

A square configuration of four chairs allows for most techniques and enables the therapist and client to seamlessly move into new seats (Neimeyer, 2012). Keeping extra chairs available is always advisable (see Figure 16.1).

Therapist positioning

Therapists will usually place themselves slightly outside of the client's line of vision during chairwork to ensure attention is focused on the opposing chair. When speaking with distressing self-parts (e.g. a negative core belief), therapists may locate themselves nearer to the client so that support can be provided. In some circumstances, it may be appropriate if therapists adopt a more impartial position, such as when clients are using chairwork to formulate decisions (see Chapter 24). In this case, the therapist's seat is positioned

Cognitive behaviour chairwork: distinctive features

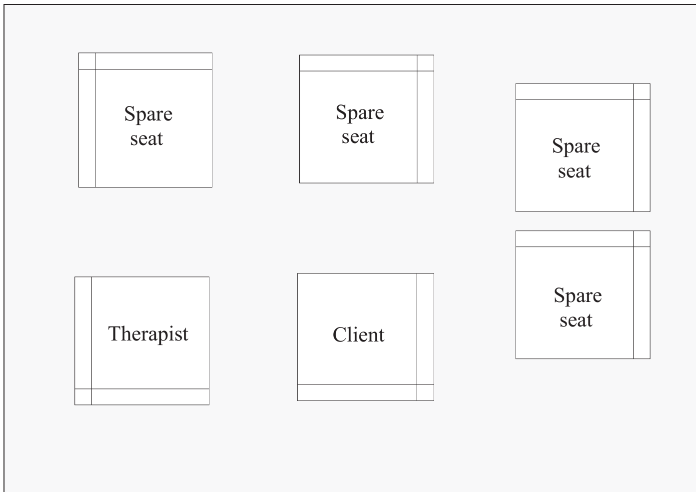

Figure 16.1 A recommended arrangement of chairs

equidistant between the other chairs. When in doubt, therapists ask the client where they should be located.

Distances

Chairs are placed at such distances that interactions between self-parts are meaningful but not obtrusive. However, clients may prefer greater distance when speaking to distressing representations (e.g. the 'inner critic'). Again, therapists ask clients how much distance between seats feels comfortable.

Directions

Chairs usually face one another so that information can be exchanged between these positions. However, there may be situations where dialogue between self-parts is unhelpful or unnecessary

(see Chapter 23 for an example). In this case, chairs are placed in parallel (i.e. side by side).

'Roling' and 'de-roling'

Clients will usually switch seats when enacting new roles to concretise changes in perspective. Similarly, therapists change chairs when performing roles. This process of 'roling' and 'de-roling' chairs ensures both parties do not become identified with distressing self-parts or persons. On the other hand, clients usually remain in their original seat when embodying adaptive self-parts to encourage alignment with these perspectives.

Turn-taking

Clients are asked to enact distressing roles for the least amount of time necessary to bring associated thoughts and feelings 'online'. In contrast, adaptive roles are enacted for longer so that these perspectives are internalised and reinforced.

Opening, closing, and consolidating chairwork

Chairwork 'markers'

CBT therapists initiate chairwork on the basis of conceptual, procedural, or process-based indications ('markers').

- *Conceptual markers* relate to indications arising in the case conceptualisation. For example, more 'dramatic' interventions such as chairwork may help engage highly extroverted individuals (Beck et al., 1990).
- *Procedural markers* refer to technical indicators for chairwork. For example, point-counterpoint chairwork (Chapter 22) is usually recommended after the evidence supporting a negative core belief has been re-evaluated using pen-and-paper exercises.

- *Process markers* refer to indictors arising within the unfolding therapeutic interaction. These indicators are further subdivided into conceptual and experiential markers.
  - *Process-conceptual* markers are theoretically informed signals for chairwork. For example, limited emotional relief following use of dysfunction thought records might indicate an overly analytic mode of information processing, in which case more evocative interventions might be called for.
  - *Process-experiential* markers refer to indicators within clients' process of cognitive-affective experiencing. For example, if an individual describes a critical internal narrative but cannot put words to these cognitions, enacting their 'critical side' may help bring NATs into sharper focus.

Introducing chairwork

Conversational analysis studies have identified effective ways to introduce chairwork (e.g. Muntigl, Chubak, & Angus, 2017). Elaborate proposals often stifle spontaneity and heighten clients' anxiety; simple, confident invitations are more effective (Therapist: "Could we try an experiment together?"). These are followed by a brief rationale for chairwork (Therapist: "I think using the chairs could help us understand this issue better; bring this problem to life; make our work feel more real"). Therapists should also expect some hesitancy when first suggesting chairwork, in which case judicious use of reassurance may be required (Therapist: "I'll help you do this; I'll be right beside you; you're in control of the process").

Closing chairwork and 'bookmarking'

Whilst chairwork usually reaches natural conclusions, time may run short. In these circumstances, therapists gently cue clients to the closure of a dialogue (Therapist: "Is there anything else you would like to say before we pause this exercise?"). If enactments need to take place over several sessions, therapists 'bookmark' important

dialogues for later continuation (Therapist: “This has been an important dialogue and one we can return to later”).

Assessing and consolidating change

Pre- and post-intervention ratings establish whether chairwork has brought about change. For example, clients rate their belief in NATs before and after two-chair cognitive restructuring to determine if cognitions have been restructured (Chapter 18). When recreating historical events (Chapter 22), clients also rate how closely the enactment matched the original experience. Thought should also be given to how chairwork can be consolidated. Useful homework assignments may include reviewing audio recordings of chairwork; composing flashcard summaries of transformative dialogues; writing to and from self-parts involved in the enactment; and collecting further information for future dialogues (e.g. positive data which can be incorporated into later dialogues with a negative self-belief). Many chairwork dialogues can also be summarised diagrammatically (‘dialogical maps’) (see Pugh, 2019).

The therapeutic relationship

Finally, the importance of the therapeutic relationship must be highlighted before moving onto practical applications of chairwork. Chairwork is an intense and emotionally demanding method of intervention which requires a robust therapeutic relationship. When clients feel held within a safe, non-judgemental, and collaborative working relationship, they are both more willing to engage with techniques and often experience greater therapeutic gains.

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Using chairwork to socialise clients to the cognitive-behavioural model and allied approaches

Early socialisation to the cognitive-behavioural model represents a key task in CBT. Therapists begin this process by describing the client's presenting difficulties in cognitive and behavioural terms, perhaps using a five-systems conceptualisation (Padesky & Mooney, 1990). Chairwork can socialise clients to the cognitive-behavioural model in a more experiential manner. Once a cross-sectional formulation has been developed, a triangular formation of three chairs is introduced: a 'thoughts' chair, a 'feelings and physiology' chair, and a 'behaviour' chair. Using a recent example of distress, the client then speaks from each chair in sequence to experience how cognitions, emotions, and behaviour influence each other.

Jane's therapist has presented a five-systems conceptualisation of her eating difficulties.

Therapist: How about we bring this diagram to life?
Jane: Ok.
Therapist: Imagine this chair represents your negative automatic thoughts [*introduces chair one*], this chair represents your emotions [*introduces chair two*], and this chair represents your behaviour [*introduces chair three*]. Can you take a seat in the 'thoughts chair'? [*Jane switches*].

(*Inviting Jane to 'speak as' her NATs heightens affect and externalises these cognitions*).

Therapist: Now, speak as the negative thoughts you experienced at dinner yesterday. Tell Jane about the bad things that might happen if she eats. [*Gestures to the 'emotions chair'; chair two*].

Jane: [*Speaking to chair two*]. If you eat you'll become a fat, disgusting slob.

(*Switching seats at this point helps Jane distinguish her NATs from her emotional reactions*).

Therapist: Can you move to the 'emotions chair'? [*Jane moves to chair two*]. How do you feel hearing that?

Jane: I feel nervous. I don't want to get fat.

Therapist: Where do you feel that nervousness?

Jane: It's like a knot in my stomach.

(*Switching seats once more helps Jane differentiate her emotions from her behavioural motivations*).

Therapist: How about moving to the 'behaviour chair'? [*Jane switches to chair three*]. You're doing great, Jane. So, when these thoughts run through your mind [*gestures to chair one*] and generate this feeling of anxiety [*gestures to chair two*], what do you want to do?

Jane: I want to purge everything I've eaten.

Therapist: Those NATs create an urge to vomit, huh? [*Jane nods*]. Does this connection between your thoughts, feelings, and behaviour make sense? . . .

Therapists might extend this task by demonstrating how adjusting one's thinking can ameliorate distress. For example, Jane's therapist might ask her to return to the 'thoughts chair' and speak as if she were comforting a friend (Therapist: "Imagine a friend sat in the 'emotions chair' – if she felt scared about eating and weight gain, what would you say to help her feel more comfortable?"). Jane would then move to the 'feelings chair' and reflect on any subsequent changes in her emotions.

Socialisation to allied models of therapy

Approaches allied with CBT also describe multiple systems of experiencing. For example, CFT identifies three affect-regulation systems related to threat, drive, and safeness; schema therapy describes parent, child, and coping modes of processing; DBT recognises emotional, rational, and wise mindsets. Socialisation to these frameworks through chairwork can be facilitated in two ways. First, arrangements of chairs are used to illustrate how these systems interact ('putting the therapy model on chairs'). Second, asking the client to embody each system in different seats builds familiarity with their unique characteristics.

Kabir's therapist has presented the three affect systems described in ***compassion-focused therapy****.*

Therapist: Let's get to know these three systems better. Imagine this chair represents your threat system [*introduces chair one*], this chair represents your drive system [*introduces chair two*], and this chair is your safe and soothed system [*introduces chair three*]. Which system feels biggest and most active for you right now?

Kabir: I'd say the threat system.

Therapist: Let's start there. Take a seat in the 'threat chair'. [*Kabir switches*]. I know it might feel uncomfortable, but let's really connect with this system. Has there been a recent situation which brought up that sense of threat?

Kabir: I can't stop worrying about my presentation next week.

Therapist: Good example. So feelings of anxiety go with this system? [*Kabir nods*].

(*Using present-tense language at this point encourages Kabir to connect with his threat system in the here-and-now*).

Therapist: Where do you experience that anxiety in your body?

Kabir: I feel sick to my stomach.

Therapist: What thoughts do you notice accompanying that nausea?

Kabir: I'm scared my colleagues will think I'm pathetic for being nervous.

(*The phrase 'Anxious Kabir' helps the client recognise that this is just one experience of his self*).

Therapist: What does 'Anxious Kabir' want to do in situations like these?

Kabir: I want to call in sick.

Therapist: So, you can see how the threat system organises the mind in powerful ways. There's anxiety, feeling nauseous, worrying thoughts, and a motivation to protect yourself by escaping. [*Kabir nods*]. How about we move on to the drive system?

(*Movement is now used to help Kabir distance himself from his active and over-learned threat-system*).

Therapist: Before we do that, let's try stepping back from the threat system by taking a stroll around 'Anxious Kabir's' seat. [*Both walk around the chair a few times*]. . . . Feel ready to change systems? [*Kabir nods*]. Great. Can you move to the second chair? . . .

Kabir now embodies his other affective systems in different chairs.

Jane's therapist is introducing the concept of ***schema modes***.

Therapist: It sounds like introducing the meal plan was tough.
Jane: It was. I just couldn't do.
Therapist: Perhaps exploring this task from the perspective of your modes might help us understand what made it so challenging. When you thought about introducing the meal plan, did any modes come up?
Jane: Definitely the critical one.

(*Chairwork begins with enacting Jane's most active mode*).

Therapist: Sounds like the punitive mode. [*Introduces a new chair*].

(*Inviting Jane to speak as her punitive mode helps her to 'step into the shoes' of this self-part*).

Therapist: Can you change seats and speak as that part of your self? [*Jane switches seats*]. What does your punitive mode have to say about introducing the meal plan?
Jane: I'm a fat slob and don't deserve to eat.
Therapist: That mode is so attacking, huh? [*Jane nods, looking tearful*].

(*Enacting the punitive mode seems to have activated Jane's vulnerable child mode*).

Therapist: Change seats and be 'Little Jane' now. What does this mode think about the meal plan?
Jane: [*Changes seats*]. I'm so scared about eating more. What if I have too much? . . .

Janes speaks from the perspective of her other modes in different chairs.

Kabir's therapist is introducing the idea of 'mindsets' as described in ***dialectical behaviour therapy****.*

Therapist: So it's difficult to know how to respond to your manager's critical feedback?
Kabir: Right. [*Sighs*]. All I know is I feel really low.
Therapist: Do you remember we talked about those three mindsets?
Kabir: Emotional mind, rational mind, and wise mind?

Therapist: Right. How about we explore what each mind-set wants to do about this situation? [*Kabir nods*]. Come and take a seat in 'emotional mind'. [*Introduces chair one*]. What does this part think, feel, and want to do?

Kabir: That's easy. [*Switches seats*]. This side just wants to give up and go back to bed. I never do anything right.

Therapist: How does rational mind respond? [*Introduces chair two*]. . . .

Kabir embodies each mindset in different chairs.

18

Using chairwork to address negative automatic thoughts

Eliciting, restructuring, and distancing from NATs represent core therapeutic procedures in CBT. Often overlooked, chairwork provides another means to assess and modify NATs. These evocative techniques are often recommended when NATs are entrenched or if other restructuring methods have proved ineffective.

Two-chair techniques

Two-chair methods are most commonly applied to NATs. These interventions have collected numerous titles including the externalisation of voices, reverse advocacy, and rational-emotional role-play. In reality, two-chair cognitive restructuring utilises four core forms of dialogue.

Self-other dialogues

Self-other dialogues involve the client challenging NATs belonging to another individual (enacted by the therapist) which are thematically similar to their own (Beck, Emery, & Greenberg, 1985). This technique capitalises on the ability to counteract others' cognitions more objectively than one's own.

Therapist: Imagine this chair holds someone similar to yourself, Kabir. [*Introduces chair one*]. Let's call him Kush.

(*The therapist highlights the similarities between 'Kush' and Kabir*).

Therapist: Kush has had a similar life to you and now finds himself experiencing similar NATs. I'm going to enact Kush and I'd like you to help me feel better. [*Switches seats*].

(*Switching seats highlights that the therapist is changing roles. Kabir remains in his original chair to help align him with the 'healthy' perspective being stimulated. NATs which are similar to Kabir's are now presented by the therapist*).

Therapist: [*Enacting 'Kush'*]. Kabir, I'm giving a presentation soon, but I'm concerned my colleagues will lose respect for me if they notice my anxiety. What do you think?

Kabir: I imagine your colleagues respect you for your competence, not just how well you present.

Therapist: But why am I the only one who gets nervous during presentations?

Kabir: You're not. Most people get anxious when they present.

(*Guided discovery now links the content of chairwork to Kabir's own NATs*).

Therapist: [*Returns to original chair*]. Good work, Kabir. How might the things you just said apply to your own NATs? . . .

Self-other dialogues can also be used to problem-solve and reinforce homework assignments (Beck, Rush, Shaw, & Emery, 1979). For example, the therapist might enact a naive 'patient' who is

instructed by the 'clinician' (played by the client) regarding how and why homework tasks are implemented.

Therapist: So starting a food diary sounds helpful?
Jane: I think so.
Therapist: Great. Let's do some preparation.

(*Chairwork is used to assess whether Jane grasps the rationale and implementation of this task*).

Therapist: I'm going to pretend to be someone new to food diaries. You play the therapist and give me some guidance around completing this homework. Ready?
Jane: Go for it.
Therapist: [*Changes seats and speaks a naive 'client'*]. So why should I use a food diary?
Jane: [*As the therapist*]. Well, writing down what you eat will help us understand your eating disorder better. Diaries also help with meal planning.

(*Recording episodes of binge-eating is going to be emotionally demanding for Jane. The therapist uses chairwork to help Jane problem-solve this obstacle from a 'self-distanced' perspective*).

Therapist: But what if I binge? It would be upsetting to record that.
Jane: [*Thinking*]. . . . Writing down when you binge is particularly important. I know it's tough to do, but it will help us address your triggers together.
Therapist: Any ideas about what might help me do that? . . .

Other-other dialogues

Other-other dialogues involve evaluating NATs from a distanced, third-person perspective. In attorney role-plays, evidence supporting a NAT is first presented by a 'prosecuting attorney' (enacted by the client in chair one), followed by counter-evidence presented by a 'defence attorney' (enacted by the client in chair two). Exploring NATs in this distanced manner is particularly helpful when cognitions generate intense distress. Furthermore, clients do not need to believe their defensive arguments whilst enacting an attorney; they simply need to present this evidence as persuasively and 'professionally' as possible (Leahy, 2003).

Therapist: Let's begin by playing Jane's 'internal prosecutor' over here. [*Introduces chair one*]. From this chair, I'd you to present the evidence which shows Jane is greedy for eating dessert. Ready? [*Jane changes seats*].

(*The therapist inducts Jane into this new role*).

Therapist: So, prosecutor, what are your arguments?
Jane: Dessert is unnecessary. *That* makes Jane greedy. . . .

Jane presents further evidence supporting her NAT.

Therapist: . . . Come over to this chair, Jane. [*Jane switches into chair two*]. Here, I'd like you to enact Jane's 'defence attorney'. Imagine you've been hired to defend her against this allegation of greed. It's important to present your arguments as persuasively as possible, ok? [*Jane nods*]. How would this side defend Jane?
Jane: Everyone eats dessert. It's unfair to label Jane as greedy for doing something normal. . . .

Other-self dialogues

Other-self dialogues involve responding to one's NATs from the perspective of another individual. Therapists initially model this 'healthy perspective' (in chair one) by challenging NATs presented by the client (from chair two). In doing so, clients are exposed to compelling counter-arguments. Later, clients respond to their own NATs by adopting the healthy perspective of other persons.

Jane: [*Visibly shaking*]. I can't believe I've gained one kilogram. I'm losing control!

(*Jane's intense anxiety suggests that restructuring this NAT from an external, rather than self-immersed, perspective may be most productive*).

Therapist: Who provides good advice when you need it, Jane?
Jane: [*Thinking*]. . . . My grandma, Beatrice.

(*The therapist assesses whether Jane experiences her grandmother's advice as constructive and supportive*).

Therapist: What's Beatrice like?
Jane: She's lovely. She always helps me feel better when I'm upset.
Therapist: I wonder what she'd think about this situation. Would you mind changing seats and being the voice of your grandma? [*Jane switches chairs*].

(*Switching seats disrupts Jane's ruminatory thinking, whilst addressing her as 'Beatrice' immerses her in this new role*).

Therapist: Beatrice, your granddaughter is really worried she's lost control because she's gained one

kilogram. Can you give her any guidance? [*Gestures to Jane's former chair*].

Jane: [*As Beatrice, speaking to the empty chair*]. One kilogram isn't too much weight, Jane. Think about the progress you're making.

(*The therapist expands on these counter-arguments*).

Therapist: What else can you say to help Jane see this situation differently? . . .

Self-self dialogues

Self-self dialogues involve the client presenting both the evidence supporting their NAT (in chair one) followed by disconfirmatory evidence (in chair two). As the client switches chairs and plays both sides of the thought, the cognition is gradually restructured. Therapists can also coach the client in formulating compelling counter-arguments, when needed.

Advanced two-chair techniques

Advanced two-chair methods are more evocative the techniques discussed previously and are usually introduced when clients are familiar with both chairwork and cognitive restructuring. Padesky (1997) has described a method for resolving fears of negative evaluation through role-plays involving 'defence of the self'. Here, the therapist embodies the NAT in the form of a critical 'other', whilst the client responds with either assertive counter-responses or dignified acceptance (i.e. recognising the limited truth in the criticism without becoming submissive) (Burns, 2018a). This technique desensitises clients to these 'interpersonal catastrophes' and can help transform external shame into adaptive anger.

Therapist: So your worst fear about a colleague noticing your anxiety is that they'll think you're weak? [*Kabir nods*]. I have an idea. I'm going to change seats and pretend to be a really critical workmate, as if this worst fear has come true. Your job is to defend yourself against this accusation, ok?

Kabir: Ok.

(*The therapist reiterates that the forthcoming comments are not personal attacks*).

Therapist: Remember, the things I'm going to say aren't things I believe. [*Kabir nods*]. [*Changes seats and enacts a critical colleague*]. Kabir, I noticed your anxiety whilst you were presenting and I thought, "Man, that guy is so weak!" What do you think about that?

Kabir: [*Silent*]. . . . That's a bit harsh. I did get anxious but that's not so abnormal. It doesn't mean I'm weak.

(*Kabir's successful self-defence prompts the therapist to present more evocative criticisms*).

Therapist: Yes, it does! I think anxiety is a massive sign of weakness.

Kabir: That's rubbish. Are you telling me you never get anxious? If you really are that judgemental, your opinion doesn't count for much.

(*The therapist now evaluates whether chairwork has been constructive*).

Therapist: [*Leans forward*]. Which of us won that exchange?

Kabir: I did! . . .

Playing 'devil's advocate' (Goldfried, Linehan, & Smith, 1978) is another evocative procedure which involves the therapist cross-examining the client's healthy responses to their NATs. Therapists become increasingly challenging as the dialogue progresses, thus encouraging the client to become more forceful in their counter-responses.

Therapist: After completing this thought record, how much do you believe the balanced thought, "Feeling full is tolerable and doesn't mean I'm gaining excessive weight"?
Jane: About 70%.

(*Chairwork might help build Jane's conviction in this balanced thought*).

Therapist: Let's make it feel more convincing. I'm going to switch seats and, when I do, I'll try to undermine this healthy thought. You need to defend it. Let me know if you get stuck so that we can develop some solid counter-arguments together. [*Therapist change seats and speaks as Jane's NATs*]. Jane, feeling full is intolerable.
Jane: Not true. I've tolerated it before and I can again.

(*Jane's ability to counter-argue prompts the therapist to 'turn up the heat'*).

Therapist: But it's just so uncomfortable.
Jane: That feeling will pass. I just need to hang in there.
Therapist: But feeling full means you're getting fat.
Jane: Nope, feeling full after eating is normal. . . .

Multi-chair techniques

Three-chair cognitive restructuring integrates a third 'emotions' chair into the two-chair approach. This benefits the client by encouraging greater emotional arousal, processing, and reflection during the process of reappraisal. A triangular formation of chairs is used.

Therapist: Let's begin by moving to the chair representing the NAT, "I'm a bad father". [*Kabir moves from chair one to chair two*]. Now, imagine Kabir sat in this seat. [*Touches chair three*]. Speaking as Kabir's NATs, tell him what makes him a bad father.

Kabir: [*Speaking to chair three*]. You're a bad father because you don't spend enough time with your kids. You can't even collect them from school on time. . . .

Kabir presents further evidence supporting his NAT.

Therapist: . . . Come over to this chair. [*Kabir moves to the 'emotions seat'; chair three*]. How do you feel hearing that evidence?

Kabir: Really guilty. [*Becomes tearful*].

(*Encouraging emotional processing*).

Therapist: What happens inside when you experience that guilt?

Kabir: I feel sick to my stomach.

Therapist: It must be hard carrying that guilt around, Kabir [*Kabir nods*]. What does that feeling say to you?

Kabir: I never get anything right. I ought to disappear.

(*Kabir is encouraged to align with his 'rational side' by embodying this perspective in his original chair)*.

Therapist: Come back to your first chair, the 'healthy seat' [*Kabir returns to chair one*].

(*The therapist now uses gesture and instruction to encourage decentring*).

Therapist: Let's shake off that NAT [*gestures to chair two*] and set the guilt aside for a moment [*gestures to chair three*]. Take a deep breath. . . . [*Kabir breathes deeply*]. . . . Great. Feel ready to continue?
Kabir: I think so.
Therapist: Ok. Now, thinking back to what your NAT said [*gestures to chair two*], did you notice any thinking errors when it spoke?
Kabir: [*Thinking*]. . . . Selective attention, maybe? I do some good things for my kids.
Therapist: Like what?
Kabir: I cook them healthy meals.

(*The therapist prompts Kabir to challenge his NATs directly*).

Therapist: Say that to the NAT. [*Gestures to chair two*]. "I'm a good father because I make my kids healthy meals". . . .

Once the NAT has been fully restructured, therapists conclude this exercise by inviting the client (remaining in the 'healthy seat', chair one) to soothe their distressing emotions held in the 'feelings seat' (chair three). For guidance on self-soothing through chairwork, see Chapter 19.

Empty-chair techniques

Empty-chair techniques are used less often when working with NATs but are nonetheless effective. When distressing or task-interfering cognitions arise during the session, therapists can encourage defusion by inviting the client to 'set aside' these thoughts in an empty seat.

Therapist: Did you complete your positive data log?
Jane: I wrote some things down. Nothing special.

(*The therapist highlights Jane's task-interfering cognition*).

Therapist: Whoa! Did you see that NAT try to discount your positive data?

(*The therapist uses an empty chair to facilitate defusion*).

Therapist: Let's put that thought in this empty seat [*introduces a chair*] and go back to your logs. So, tell me what you recorded. . . .

Mental imagery

It is worth briefly noting that NATs also manifest as distressing mental images (Hackmann, Bennett-Levy, & Holmes, 2011). Chairwork has long been used to modify these experiences. For examples of two-chair dialogues with mental images, see Perls (1969) and (for a cognitive perspective) Edwards (1989).

19

Using chairwork to address problematic emotions

Alongside the mainstays of cognitive restructuring and decentring, CBT incorporates techniques for managing distressing emotions more directly. Experiential approaches to enhancing emotional regulation, including chairwork, are particularly effective (Thoma & McKay, 2015).

Clarifying emotions

Chairwork techniques are used to elucidate emotional experiencing in CBT. 'Multiple (emotional) selves' (Gilbert, 2009) invites the client to embody specific feelings in separate chairs (e.g. the 'Sad-', 'Angry-', and 'Anxious Self') (see Chapter 25 for detailed discussion). In doing so, aspects of emotional experience are clarified and elaborated, including associated motivations, body-states, and memories. By 'stepping in' and 'stepping out' of these emotions, clients also learn that these affective states are tolerable, important, and valid. Not all emotional experiences are this clear-cut, of course. Sometimes clients experience more nebulous feelings which appear disconnected from cognitive processes (Client: "I don't why I feel empty, I just do"). Again, asking the client to embody these affective states can help determine their cognitive, behavioural, and somatic dimensions (Therapist: "Switch seats and be 'emptiness'. How does emptiness sit? What does it see, hear, and feel? Give emptiness a voice. What does it think, say, and want to do?").

Decentring from emotions

In order to process emotions effectively, clients sometimes need to establish a 'psychological distance' from these experiences. 'Physicalising' emotions combines elements of EFT and ACT (Hayes, Strosahl, & Wilson, 2012; Elliott, Watson, Goldman, & Greenberg, 2004) and involves representing intense affect as a multisensory percept held in the empty chair. This representation of emotional experience is then transformed in such a way that affect is down-regulated.

Jane: I'm terrified about today's weight check.
Therapist: On a scale of 0 to 100, how high is your anxiety right now?
Jane: 150!

(*Jane is encouraged to decentre from her anxiety by visualising it outside of herself*).

Therapist: Suppose we placed your anxiety in this seat. [*Gestures to an empty chair*]. What would it look like?
Jane: [*Thinking*]. . . . It would be a whirlwind.

(*Jane imagines other sensory qualities of her emotion*).

Therapist: What colour would it be?
Jane: Grey, like a hurricane.
Therapist: How would it sound?
Jane: Like rushing wind.
Therapist: How high is your anxiety now?
Jane: A little less. 98.

(*Because Jane's anxiety is only slightly reduced, additional suggestions for transforming this emotion are provided*).

Therapist: What if we shrunk the whirlwind to the size of a football? Would that help?
Jane: Maybe.
Therapist: Imagine that. The whirlwind getting smaller. . . . The wind becoming quieter. . . . Can you picture that? [*Jane nods*]. How high is your anxiety now?
Jane: About 70.
Therapist: What else might help? We could put the whirlwind under your chair or outside the room? . . .

Expressing emotions

Emotional expression is used to relieve intense emotions in CBT ('ventilation') (Leahy, 2003). Whilst written exercises are ordinarily used for this purpose, chairwork offers a more evocative medium for expressing affect.

Kabir: I don't know why David hassles me about not going drinking with him. He knows I'm trying to stay sober.
Therapist: You sound angry as you say that.
Kabir: I am. He's a jerk for pressuring me so much.

(*The therapist is aware Kabir struggles to express his anger. Chairwork might help him vent this emotion*).

Therapist: Imagine David were sitting here. [*Introduces an empty chair*]. Tell him about your anger.
Kabir: [*To the empty chair*]. You shouldn't pressure me to go drinking with you.

(*Kabir's anger seems muted. The therapist attempts to heighten his emotional expression*).

Therapist: Tell him again, but louder this time.
Kabir: [*Shouting*]. You're a jerk for pressuring me! . . .

Ventilation through chairwork can serve other therapeutic functions. These include testing out beliefs about heightened arousal, overcoming emotional avoidance, and rehearsing emotional disclosure.

Soothing emotions

Self-soothing is facilitated by first inviting the client to express their distress in chair one; then responding to these emotions with care and validation in chair two; and finally experiencing receiving this care by returning to chair one again. Numerous frames can be used to facilitate this process of 'two-chair self-soothing' (see Sutherland, Perakyla, & Elliott, 2014). These include self-to-self soothing (Therapist: "Change seats and see your self experiencing this suffering in your former chair; what support can you offer your self?"); soothing one's inner child (Therapist: "Imagine your self in the empty chair as a vulnerable child; what would you say to soothe that child's pain?"); or soothing a loved one (Therapist: "Imagine a close friend in the opposite chair in similarly upsetting circumstances; how would you care for them?"). Chairwork can also be

used to experience care from the embodied perspective of a 'soothing other':

Therapist: Who helps you feel better when you feel overwhelmed, Jane?
Jane: My sister, Melissa. She's always there for me.

(*The therapist assesses whether Jane experiences her sister's care as soothing*).

Therapist: How does Melissa respond when you feel upset?
Jane: She doesn't just give me advice. She also listens and understands how hard things can be for me at times.
Therapist: Let's imagine she were here with us. [*Introduces a chair*].

(*The therapist now assesses whether Jane has made 'emotional contact' with this representation of her sister*).

Therapist: What's it like seeing Melissa over there?
Jane: [*Looking at the empty chair*]. It's nice.
Therapist: Change seats and be her voice for a moment. [*Jane switches seat*].

(*The therapist inducts Jane into this soothing role*).

Therapist: Melissa, Jane has had a rough week. She's eating more but it's been so, so scary. Hearing that, how do you feel towards her?
Jane: I know it's tough for her. Getting better is hard.

(*The therapist invites 'Melissa' to direct her care towards Jane*).

Therapist: What would you like to say to Jane to help her feel less overwhelmed? [*Gestures to Jane's former chair*].

Jane: [*To the empty chair*]. I know eating is hard for you, but it will get easier. Hang in there. I'm so proud of what you're doing. I'm with you all the way.

(*Expanding upon Jane's positive qualities will help her feel more soothed and contained*).

Therapist: What else do you value in Jane, Melissa? Can you tell her?. . .

It is often helpful to conclude two-chair self-soothing by highlighting the omnipresence of this source of support (Therapist: "This soothing part is always with you and there whenever you need it").

Processing emotions

Processing difficult feelings can quickly descend into unproductive rumination. Adopting a distanced perspective on intense emotions allows for a 'cooler' reflection on troubling experiences (Kross & Ayduk, 2016). 'Self-distancing' is operationalised through chairwork by changing seats and reflecting on why emotions have occurred from a third-person perspective.

Kabir: I can't stop thinking about why David keeps nagging me to go drinking with him.

(*Because Kabir tends to ruminate, reflecting on this emotional reaction from distanced perspective may be more productive*).

Therapist: Let's explore this situation as if we're observing what's happening for Kabir. Can you take a seat beside me? [*Kabir switches*].

(*The therapist uses third-person language to encourage self-distancing*).

Therapist: Thinking about Kabir over there [*gestures to Kabir's former seat*], what are his reasons for feeling angry about this situation?
Kabir: He's trying to stay sober but his friends aren't helping. Actually, they're doing the opposite.
Therapist: Right. Kabir seems particularly angry about his best buddy, David, pressuring him to drink. Why do you think that has annoyed him so much?
Kabir: Kabir thinks good friends don't do that. He wants his best friend to support him.

(*Kabir is now encouraged to reflect on the meanings underlying his anger*).

Therapist: What might Kabir's anger be telling him?
Kabir: That he needs and deserves better support from his friends. . . .

Managing emotions

Speaking to oneself in the second-person is an effective means to regulate emotions (Kross & Ayduk, 2016). Accordingly, chairwork can be used to rehearse real-time self-instruction in anticipation of distressing events ('emotion coaching').

Jane: I'm really nervous about going to the buffet. I don't know what to eat, how much to eat, what other people might be thinking . . . I don't think I'm going to cope.

Therapist: Perhaps some emotion coaching might help with this situation.

(*The therapist introduces another chair to help Jane 'step back' from her anxiety*).

Therapist: Imagine this chair holds 'Anxious Jane'. [*Introducing a new chair*]. This is the moment where she's about to walk up to the buffet and she's feeling really anxious. Let's try and coach her through these difficult feelings.

(*The therapist uses present-tense language to frame emotion coaching as a 'real-time' intervention. The therapist begins by modelling the process of emotion coaching*).

Therapist: I'll start us off. [*Turns to the empty seat*]. Ok Jane, this is a scary situation. The anxiety feels intense but you're going to be ok. [*Turns to Jane*]. Can you take over?

Jane: [*To the empty chair*]. It's going to be alright.

(*Jane is prompted to elaborate on this theme of safeness*).

Therapist: Good. What else can you say to help her feel safe in this situation?

Jane: The anxiety will pass. Remember what you discussed in therapy – it rises and falls.

(*Jane's attention is directed towards practical strategies she can instruct herself to use*).

Therapist: Talk her through the ways she can cope right now. Reminding her of the breathing techniques we've practised might help? . . .

Clients sometimes struggle to decentre from intense feelings during emotion coaching. Standing (rather than changing seats) can be an effective way to interrupt acute affect and curtail preservative patterns of thinking (Therapist: "Let's stand up and leave 'Angry Kabir' in this seat. . . . Take a walk around the chair if you like. . . . Now, looking at 'Angry Kabir' from above, let's coach him in managing this feeling of annoyance").

Emotional inhibition

Emotional inhibition can limit the effectiveness of interventions such as cognitive restructuring. Chairwork is used to resolve emotional suppression and avoidance in various ways. These include 'setting aside' maladaptive beliefs about emotional expression (Therapist: "Try placing the belief, "I shouldn't experience my feelings", in this empty chair. You can take that belief home later but, for now, allow yourself to connect with your sadness"). Alternatively, clients can experiment with embodying their 'emotionally hidden' self (Therapist: "I'd like to get to know the emotional part of you that other people don't get to see – can you change seats and connect with your vulnerable side?"). Negotiating with the self-parts which facilitate emotional detachment is also productive (see working with the 'detached protector'; Chapter 26).

20

Using chairwork to assess and modify behaviours

Chairwork has long been applied to the assessment and modification of behaviour. Role-play has proven to be a particularly effective way to establish new skills and develop insight into maladaptive patterns of behaviour.

Behaviour assessment

Behaviour deficits are readily assessed using therapist-client role-plays (Therapist: "Let's role-play how you might initiate a conversation with a stranger"). Role-plays can also be repeated at the end of therapy to measure behaviour change. Recreating troubling scenarios in-session is a particularly effective means to elicit cognitions which inhibit adaptive behaviour (Beck, Emery, & Greenberg, 1985).

Kabir is recreating a challenging conversation with his manager.

Kabir: I'm sorry to raise this again, but please can we discuss my salary?
Therapist: [*Enacting Kabir's manager*]. Why?

Kabir: Well, my pay hasn't been reviewed for some time.
Therapist: I'm busy right now.
Kabir: Oh, sorry to have bothered you. [*Silent*].
Therapist: Let's pause role-play.

(*The therapist assesses whether role-play matches Kabir's lived experience*).

Therapist: Was that similar to what happened at work?
Kabir: Yes.
Therapist: How are you feeling right now?
Kabir: Pretty anxious.

(*Kabir's anxiety suggests that role-play has elicited his 'hot' NATs*).

Therapist: What's running through your mind?
Kabir: It's rude of me to ask for a salary review. I'm being presumptuous. . .

Behaviour training

Behaviour skills training (BST) is a well-researched framework for developing new behavioural repertoires (see Table 20.1). BST makes extensive use of role-play techniques, both in terms of modelling adaptive behaviour and consolidating these through rehearsal.

Table 20.1 Stages of behaviour skills training ('I-MARCHED')

1. *Instruction*: The therapist describes the rationale for the new behaviour and the steps it involves.
2. *Modelling*: The therapist demonstrates the behaviour through role-play.
3. *Assess learning*: The therapist checks whether the client believes the behaviour is effective and understands how it is implemented.
4. *Rehearsal*: The client practises the new behaviour through role-play.
5. *Coaching*: If needed, role-plays are paused so that 'live' feedback, coaching, and instruction can be provided to the client.
6. *Helpful feedback*: The client appraises their performance. The therapist praises their efforts (reinforcement) and offers additional (corrective) feedback.
7. *Edited rehearsal*: The skill is rehearsed once more incorporating corrective feedback.
8. *Develop homework*: New behaviours are rehearsed and reinforced through homework assignments (e.g. imaginal rehearsal; behavioural experimentation; reading, etc.).

Modelling

Therapists initially use role-play to model functional behaviours during BST. By enacting the 'other', clients are also able to assess the effectiveness of these new repertoires and how they are experienced by others. This can help correct both dysfunctional assumptions (e.g. "saying no to others is impolite") and erroneous expectations about how others will respond. Other forms of role-play can be used to supplement modelling. To highlight key components of new skills, therapist might utilise successive role-plays involving demonstrations of poor performance (i.e. maladaptive behaviour) immediately followed by enhanced performance (i.e. adaptive behaviour) (Mueser, 2018). Contrasted role-plays, on the other hand, expose the client to multiple behaviours to illustrate their distinguishing features (McNeilage & Adams, 1979).

Kabir's therapist is using contrasted role-plays incorporating an empty-chair.

Therapist: I'll model three ways of approaching your manager about a salary review. See what you think of each one. [*Therapist moves to chair one*]. [*Speaking to Kabir's manager in the empty-chair*]. I'm sorry to disturb you. Please can we discuss my salary? It can wait if you're busy. [*Turns to Kabir*]. What do you think?

Kabir: That won't work. My manager would tell me to come back later.

(*The therapist now enacts the opposite to non-assertiveness. Switching seats helps differentiate these styles of communication*).

Therapist: Ok, that was a fairly passive approach. Let's try being aggressive. [*Moves to chair two and speaks to the empty chair*]. Stop what you're doing and listen! I demand a pay rise! [*Turns to Kabir*]. This approach?

Kabir: [*Laughs*]. That's worse! I'd get fired!

(*The therapist enacts the middle-ground between passivity and aggression*).

Therapist: Let's try an assertive approach. [*Moves to chair three and speaks to the empty chair*]. I'd like to arrange a meeting to discuss my salary. This is important to me. When is that possible?

Kabir: I liked that. Being assertive could work.

(*Guided discovery is used to delineate the components of assertiveness*).

Therapist: So what did I do differently in this chair compared to the others? . . .

Exploring how other individuals respond in challenging situations can also elucidate adaptive behaviour. These skills are then enacted by the client 'as if' they were that individual or modelled by the therapist instead (under the client's direction).

Behaviour rehearsal

Later in BST, role-plays are used to rehearse new behaviours alongside therapist coaching and corrective feedback. Beck and colleagues (1985) recommend 'exaggerating' roles during these rehearsals to help build clients' confidence and expose them to the higher levels of anxiety experienced in real-world situations. For example, clients might be encouraged to amplify their assertiveness during role-play (Therapist: "Be as assertive as you possibly can in this role-play"), whilst the therapist 'over-acts' the responses of others.

Behavioural instruction

Implementing new behaviours outside of the therapy room is often challenging. Much like emotion coaching (Chapter 19), 'behavioural instruction' involves the client changing seats and providing behaviour-focused guidance and direction to their self, represented by the empty chair. To help frame self-instruction as a 'real-time' intervention, present-tense language is normally used here (Therapist: "Tell Kabir what he needs to say and do in this situation").

Behavioural exposure

Chairwork is sometimes used as a form of exposure. Role-playing anxiety-provoking situations helps desensitise clients to these events and 'road-test' coping strategies.[1] Enacting clients' 'worst case scenarios' through chairwork can also be therapeutic, insofar as clients learn that these situations are both tolerable and often far-fetched.

Therapist:	What's the worst that might happen if you told your friend you had an eating disorder?
Jane:	She'd think I'm crazy.
Therapist:	How could you respond if she said that?
Jane:	I could say I'm not crazy and they're being judgemental?

(*Role-play is used to build Jane's confidence in managing this worst-case scenario*).

Therapist:	Let's see how that response feels to you. I'll switch seats and be a super-judgemental friend and you respond in exactly that way. [*Therapist switches and speaks as Jane's friend*]. Was there something you wanted to tell me, Jane?
Jane:	Well, the reason I haven't been around lately is because I'm struggling with an eating disorder.

(*The therapist introduces humour into role-play*).

Therapist:	[*In an exaggerated voice*]. WHAT?! You have an eating disorder?! You're crazy!
Jane:	[*Laughs*]. I'm not crazy. Eating disorders are pretty common. I was hoping you'd be more supportive than that.

(*The therapist assesses whether Jane now appraises the likelihood of this scenario differently*).

Therapist: [*Leans forward*]. How likely does this scenario seem?
Jane: Not very! I doubt my friends would actually react like that.

(*Repeated role-plays are now used to desensitise Jane and consolidate her confidence*).

Therapist: Well, even though it probably won't ever happen, let's rehearse this scenario a few more times so you feel really prepared. . . .

Behavioural awareness

Finally, role-reversals – wherein the therapist re-enacts the client's behaviour – can be a powerful means to generate insight into how 'relationship-interfering' behaviours impact others.

Therapist: How do you respond when people compliment the way you look?
Jane: I usually brush it off and say something like, "Oh, it's just the lighting".
Therapist: How do you think that comes across to others?
Jane: I've never thought about it.

(*Recreating this scenario will help Jane better appreciate the impact of this behaviour*).

Therapist: How about we find out? Let's change seats – you play someone giving a compliment and I'll respond the way you usually do. [*Both move to new chairs*]. Ready?
Jane: [*Nods*]. You look nice, Jane. I love your dress.
Therapist: No, it's just the lighting. This dress is so old.
Jane: [*Thinking*].
Therapist: [*Leans forward*]. What are your thoughts?
Jane: I didn't realise how dismissive I sound.

(*Roles are now reversed to practice adaptive behaviours*).

Therapist: Would it help if we switched roles and practised responding differently? . . .

Role-reversal can also be helpful in the context of therapy-interfering behaviours. For example, Pederson (2015) describes working with a client who repeatedly rejected her therapeutic suggestions. When the therapist re-enacted this behaviour, the client better appreciated how discounting these interventions obstructed progress in therapy and might frustrate others.

Note

1. These principles can also be applied to relapse prevention: the client and the therapist enact situations which could lead to setbacks – or the actual experience of relapsing – alongside rehearsing adaptive ways of responding in such circumstances.

21

Using chairwork to address dysfunctional cognitive processes

CBT is concerned not only with distressing cognitions, but also dysfunctional patterns of thinking. Whilst self-criticism is often a focus for chairwork, these techniques have been applied to other problematic cognitive processes including worry and rumination.

Assessing cognitive processes

Enacting distressing cognitive processes is an evocative means to assess the content, tone, consequences, and origins of these experiences. 'Two-chair enactments' involve the client changing seats and giving voice to cognitive processes in the second-person.

> *Therapist:* Move to this chair and be the voice of your critical side. [*Kabir switches seats*].
>
> (*Prompting Kabir to enact his self-criticism using second-person language*).
>
> *Therapist:* Show me how you speak to your self when you're self-critical. [*Gestures to Kabir's former seat*].

Kabir: [*To the empty chair*]. You're a lousy father and a lousy husband. You can't even speak to people without getting nervous. It's pathetic.
Therapist: Come back to your first chair. [*Kabir changes seats*].
Therapist: Is that what your self-criticism is like? [*Kabir nods*]. How does it make you feel?
Kabir: I feel ashamed.

(*Links between Kabir's self-criticism and autobiographical events are explored*).

Therapist: Does your critical side remind you of anyone?
Kabir: [*Thinking*]. . . . It sounded a lot like my father. . . .

Through repeated enactments, clients are able to acquire increased psychological distance from these cognitive events and a more objective perspective on their content.

Functional analysis

Inspired by voice dialogue (Stone & Winkleman, 1989), 'intrapersonal role-play' allows therapists to explore the aetiology, functions, and metacognitive beliefs surrounding cognitive processes (Kellogg, 2015; Pugh, 2017). This intervention involves the client switching seats and 'speaking as' the cognitive process. Exploratory questions are then put to this self-part by the therapist, much like an interview (see Table 21.1). No attempt is made to bring about change during these dialogues: rather, the aim is to simply understand the cognitive process better.

Table 21.1 Interview schedule for intrapersonal role-plays

- What is your role in this individual's life?
- Where do you come from?
- Do you resemble or take after someone this individual has known?
- What situations bring you out?
- How do you interact with this individual? What do you tend to say?
- How are you trying to help?
- What concerns do you have about not performing this role?
- Are you aware of any difficulties you might be causing?

Therapist: Change seats and speak as the part of your self that worries about eating. I'd like to ask that side some questions so we can understand it better. [*Jane changes seats*].

(*The therapist speaks to Jane's 'worrying side' in a causal, conversational manner*).

Therapist: Nice to meet you, worry. Thanks for speaking with me. What's your role in Jane's life?
Jane: [*Speaking as 'worry'*]. I tell Jane about the bad things that could happen if she eats too much or gains weight.

(*The therapist explores the functions of worry*).

Therapist: What are you hoping to achieve by doing that?
Jane: [*Thinking*]. . . . I guess I'm trying to help her stay in control.

(*The therapist assesses the fears underlying worry*).

Therapist: What might happen if you didn't do that for her?
Jane: She'd probably eat too much. Then people wouldn't like her. . . .

The conclusion of this transcript illustrates how intrapersonal role-plays can help clarify the fears and vulnerabilities which drive dysfunctional cognitive processes. Self-criticism, for example, may be motivated by underlying fears of rejection. Additional seats representing the vulnerabilities which 'sit behind' these cognitive processes can then be incorporated into the dialogue (Heriot-Maitland, McCarthy-Jones, Longden, & Gilbert, 2019).

Eliciting metacognitive beliefs

Metacognitive beliefs perpetuate dysfunctional cognitive processes. These appraisals can be readily elicited through two-chair decisional balancing. This involves the client presenting the advantages (chair one) and disadvantages (chair two) of engaging in the cognitive process from different seats (see Chapter 24 for details). However, positive metacognitions are sometimes difficult to acknowledge if these seem illogical or contrary to therapy goals. If so, clients may find it easier to argue for and against these processes from a third-person perspective (Dugas & Robichaud, 2007). Attorney role-plays, for example, involve the client enacting a 'defence attorney' (chair one) who presents the advantages of engaging in a cognitive process, followed by a 'prosecuting attorney' (chair two) who presents the disadvantages (chair two) (see Chapter 18 for details).

Modifying cognitive processes

Simple yet transformative, modifying cognitive processes is stimulated by encouraging the client to assert their emotional needs in response to re-experiencing these events through chairwork.

Therapist: Change seats and be your permissive thoughts around alcohol. [*Kabir switches*]. Can you speak as the permissive side? [*Gestures to Kabir's original chair*].

Kabir: [*Speaking to his first chair*]. Go on, have a drink. One won't hurt. You've earnt it.

Therapist: Switch back. [*Kabir returns to his original chair*]. How do you feel hearing that?

Kabir: Annoyed.

(*The therapist clarifies the meaning of Kabir's anger*).

Therapist: What makes you angry?

Kabir: That way of thinking has caused so many relapses. It's never one drink.

(*Kabir is encouraged to express the needs underlying his anger*).

Therapist: What do you need from the permissive side?

Kabir: I need it to stop tempting me.

Therapist: Tell it. [*Gestures to the chair representing permissive thinking*].

Kabir: Stop tempting me. It is not helpful.

(*Kabir's anger and associated needs are now used to formulate rebuttals to his permissive thinking*).

Therapist: Tell that side why it's unhelpful and untrue. . . .

Clients sometimes find it difficult to confront cognitive processes from a self-immersed perspective. Alternative methods can include responding to the process as if it were directed towards a loved one

(Therapist: "How would you respond if this worrying side were telling your daughter about these catastrophes?") or removing the chair representing the process (Therapist: "Shall we take the 'rumination chair' out of the room?").

Modifying metacognitive beliefs

Reverse role-plays are used to highlight the deleterious effects of maladaptive cognitive processes, thus challenging positive metacognitive beliefs (Beck, Rush, Shaw, & Emery, 1979).

Therapist: Let's test out whether worry really is helpful. I'm going to change seats and enact the process of worrying. I'd like you to try to adjust the way I'm thinking. Be warned, I'll be persistent! [*Both move to new seats*]. Ready?
Jane: Ok.

(*The therapist presents worrying thoughts which are similar to Jane's*).

Therapist: What if I eat too much breakfast and gain weight?
Jane: That won't happen.
Therapist: What if it did?
Jane: A little more cereal can't cause weight gain.
Therapist: What if I'm different than other people?
Jane: [*Laughs*]. I get the point!

(*The therapist explores the conclusions Jane is drawing*).

Therapist: [*Leaning forwards*]. Which is?
Jane: It's never ending! I guess worrying doesn't really get me anywhere, does it? . . .

Asking the client to do to another person what they do to themselves provides another illustration of the harm caused by processes like self-criticism (Baumgardner, 1975; Beck et al, 1979). This role-play involves the client speaking as a dysfunctional cognitive process (e.g. self-critical thoughts) whilst the therapist enacts a person experiencing that process.

Kabir: [*Enacting self-criticism*]. You never get anything right.

(*The therapist responds submissively to this attack, drawing attention to the cognitive consequences of self-criticism*).

Therapist: [*Enacting a self-critical individual*]. You're right. I always fail.
Kabir: You're a mess.

(*Highlighting the behavioural consequences of self-criticism*).

Therapist: It's true. I suppose I shouldn't apply for that promotion then.
Kabir: Don't bother. Who'd promote a loser like you? [*Silent*].

(*Highlighting the emotional consequences of self-criticism*).

Therapist: Nobody. Everything feels so pointless.
Kabir: [*Looking uncomfortable*]. I don't like being this critical side.

(*The therapist clarifies Kabir's learning*).

Therapist: [*Leans forwards*]. What are you thinking?
Kabir: Putting myself down like this is pretty cruel. . . .

22

Using chairwork to modify negative core beliefs

Schemas refer to generalised knowledge structures which govern information processing. Core beliefs are verbal representations of schemas and manifest as fixed, absolute statements regarding the self, others, and the world (e.g. "I am unloveable"). Because schemas bias information processing, they are remarkably resistant to change. Accordingly, therapists combine cognitive, behavioural, and experiential interventions to modify these beliefs. Evocative techniques such as chairwork are particularly effective in this regard (Young et al., 2003).

Restructuring negative beliefs

'Point-counterpoint' (Beck, Emery, & Greenberg, 1985; Young, 1990) is an iconic chairwork technique used to modify core beliefs. This procedure is referred to as 'schema dialogues' in schema therapy and is framed as a dialogue between the maladaptive schema and the client's 'healthy side' (Young et al., 2003). First, evidence supporting the core belief is presented by the client (chair one) and rebutted by the therapist (chair two). Once able to formulate their own rebuttals, the client enacts both roles in stage two: a single piece of evidence supporting the core belief is outlined (chair one) and then refuted (chair two). If dialogues stall or counter-arguments feel unconvincing, coaching is provided by the therapist. In stage three, point-counterpoint incorporates the 'devil's advocate' technique, wherein the therapist enacts the core belief (chair one) and actively challenging the client's healthy statements (chair two).

Jane's therapist suggests moving on to the third stage of point-counterpoint.

Therapist: I'll play your core belief and I'd like you to argue back. [*Therapist changes seats*].

(*Changing seats ensures that Jane does not identify her therapist with her core belief*).

Therapist: Good to go?
Jane: Sure.
Therapist: No one cares about you. You're a burden. [*Gestures to Jane*].
Jane: Not true. My friends and family love me a lot. No one has said I'm a burden.

(*The therapist now presents evidence which Jane previously viewed as supporting her core belief*).

Therapist: But when you were small, your mum got so angry when you cried. Clearly you burdened her.
Jane: [*Silent*].

(*Jane is struggling to counter-respond; her therapist coaches her*).

Therapist: [*Leans forwards*]. Tell me why you weren't a burden as a child.
Jane: All children get upset. Mum got angry because she was unhappy in her marriage, not because I was a burden. . . .

Trial-based cognitive therapy (de Oliveira, 2015) utilises symbolic role-play to modify core beliefs. Using the analogy of a courtroom trial, this multi-chair technique begins with reconceptualising the client's core belief as a 'self-accusation' (note how this reframes this self-belief as opinion rather than fact). Next, the client enacts their internal 'prosecutor' (in chair two) and presents evidence supporting their core belief. Once this evidence is exhausted, the client enacts their internal 'defence attorney' (chair three) and outlines disconfirmatory evidence. Towards the end of the trial, the client and therapist adopt the roles of objective 'jurors' (chairs four and five) who weigh the accuracy and persuasiveness of the presented arguments. The trial concludes with the client issuing a final verdict on the original accusation.

Therapist: So, Kabir, you have been charged with being a failure. Imagine this chair holds the part of you making this allegation. [*Introduces chair two*].

(*Kabir personifies his internal prosecutor*).

Therapist: How do you picture that side of your self?
Kabir: I see a stern-looking man with an angry voice.
Therapist: Imagine this is your 'internal prosecutor'. Take a seat in his chair and speak as that side. [*Kabir switches*]. So, prosecutor, your job is to convince the court that Kabir is a failure. What are your arguments?
Kabir: Kabir has failed in numerous ways. . . .

Kabir enacts his internal prosecutor and presents evidence supporting his core belief.

Therapist: . . . Now we've heard from the prosecution, come back to your original chair. [*Kabir returns*

	to chair one]. How much do you believe this accusation now?
Kabir:	I'm convinced. 100%.
Therapist:	Well, before we reach a verdict, let's hear the other side of this story. Imagine this other chair holds your internal defence attorney. [*Introduces chair three*]. Who do you see in this seat? . . .

Kabir goes on to present disconfirmatory evidence as his internal defence attorney.

Restructuring distressing memories

Core beliefs are often rooted in distressing childhood experiences. These links become evidentiary when comparisons are made between the 'voice' of the core belief and known persons (Therapist: "Were you reminded of anyone when you spoke as your core belief?"). Confronting these individuals in the empty chair can begin a process of reframing the autobiographical events linked to the development of core beliefs.

Therapist:	It sounds like your mother's criticism growing up contributed to learning to see yourself as worthless.
Jane:	I think so. She criticised me for everything.

(*The therapist is unsure how Jane appraises her mother's past behaviour*).

Therapist:	Would you treat your daughter that way?
Jane:	Never. It's hurtful.

(*The therapist senses that Jane feels some anger towards her mother*).

Therapist: I think we should speak to your mother about this. [*Introduces a chair*]. Can you imagine her in this seat?
Jane: Yeah. She's frowning at me.
Therapist: How do you feel seeing her?
Jane: Really angry.

(*Jane is encouraged to direct these healthy emotional reactions towards her mother*).

Therapist: Tell her why you're angry.
Jane: [*To the empty chair*]. I'm angry you were always so mean to me. You had no right to put me down so much.

(*Drawing attention to Jane's unmet needs as a child, further amplifying emotion*).

Therapist: Tell her what you needed from her as a child.
Jane: [*Starts crying*]. I needed to know you loved me. . . .

Confrontation is made more evocative when parent figures are enacted by the therapist. This method comes with caveats. First, it requires a robust therapeutic alliance. Second, some childhood interactions are inappropriate to recreate within therapy. Third, therapists should only incorporate autobiographical material which the client recalls.

Kabir's therapist is role-playing his father for the purposes of confrontation. The therapist begins by reassuring Kabir that he/she does not concur with his father's attitudes.

Therapist: Before I enact your father, I'd like to be clear that the things I'm going to say aren't things I believe. I'm just recreating his behaviour.
Kabir: I understand.

(*The therapist adopts the tone and body language of a disappointed father to deepen Kabir's affect and immersion. He/she repeats statements Kabir's father has made in the past*).

Therapist: [*Therapist changes seats*]. Kabir, you're such a disappointment. Why don't you get good grades like your brother?
Kabir: I'm doing my best. So what if my marks aren't as good as his? You need to stop comparing us.

(*Kabir is prompted to be more specific is his challenges*).

Therapist: [*Leans forward*]. Tell me why it's wrong for a father to do that.
Kabir: You make me feel like a failure when you compare us. It's so unkind. . . .

'Dyadic psychodrama' (Beck et al., 1990) or 'historical role-play' (Arntz & Weertman, 1999) is another well-known method for addressing distressing memories. This technique is particularly useful if clients have formed internal attributions for parental behaviour (Client: "My mother ignored me because I was unloveable").

Historical role-play takes place across three stages. First, the client (enacting their child self) and the therapist (enacting the parental figure) recreate the distressing memory (some clients may prefer to enact both roles by moving between the seats). After this first enactment, I usually invite the client to stand and explore the event from a decentred perspective (Therapist: "Looking at this interaction from an adult perspective, how does it fail to meet this child's needs? What external factors might account for this parent's behaviour?"). Roles are reversed in the second enactment: by adopting their parent's perspective, the client acquires insights into the motivations and validity of their caregivers' actions. At the same time, the therapist challenges these toxic messages by role-playing the client's child self. In the final stage, the client enacts their child self once more and responds to the parent (enacted by the therapist) in emotionally satisfying ways.

Jane and her therapist are enacting the third stage of historical role-play.

Therapist: [*As Jane's mother*]. Jane! I told you not to eat that cake, you greedy brat!

(*Jane now repeats the statements her therapist made whilst enacting the child self in stage two*).

Jane: [*As her child self*]. Don't say that, mum. You're upsetting me. Why are you so angry?

(*The therapist repeats the statements Jane made whilst enacting her mother in stage two*).

Therapist: I'm angry because you don't listen!
Jane: It's just food, mum. The things you're saying are hurtful. I don't deserve that.

(*The therapist judges that Jane's mother would have been moved by this statement, had she been more aware of her daughter's distress*).

Therapist: . . . I'm sorry.
Jane: Is something else upsetting you?
Therapist: It's hard looking after two children. I don't know how I'm going to pay the bills.
Jane: I'm sorry you're unhappy mum, but that doesn't mean you're allowed to make me feel bad about eating. . . .

Other styles of historical role-play have been described (Roediger, Stevens, & Brockman, 2018). For example, the client might be asked to remain in the seat of the child self (chair one) following the first enactment of the memory. The child self is then interviewed by the therapist.

Therapist: Speaking as Little Kabir, why do you think your father behaved this way? How has it left you feeling? What would help you feel better? . . .

The client then switches seats and enacts the critical caregiver, who is also interviewed.

Therapist: Speaking as your father, what made you behave in this way? Are you aware of how much distress it has caused your son? Knowing his suffering, is there anything you want him to understand? . . .

Finally, the client switches into the seat of their adult self and speaks with both their child self and the caregiver.

Therapist: As your adult self, what do you think about what your father has just said? [*Gestures to the caregiver's empty chair*]. Is there anything you want to say in response? How do you imagine your father reacts to hearing that? . . . Now, looking at Little Kabir, is there anything you want him to understand about this situation? [*Gestures to the empty chair of the child self*]. What does he need to feel better? Can you say that to him? . . .

A final method for resolving distressing memories, enactive rescripting combines elements of imaginal confrontation and historical role-play.[1] First, the client (as their adult self) challenges the abusive caregiver held in empty chair one. Following confrontation, the client is re-orientated and invited to soothe their child self, held in empty chair two. Lastly, the client moves into the seat of the child self and experiences receiving this validation and support.

Therapist: Imagine your father in this chair. [*Introduces chair one*]. Do you get a sense of him being there? [*Kabir nods*]. What happens inside when you see him?
Kabir: I feel sad.

(*Kabir's sadness is used to initiate the process of confrontation*).

Therapist: Tell him about your sadness.
Kabir: [*To his father in chair one*]. I wish you could've been kinder to me, Dad. I know you were trying

to encourage me, but your criticism made me feel like such a failure.

Therapist: What did you need from him growing up?

(*The therapist takes a note of Kabir's unmet needs for the later stages of enactive rescripting*).

Kabir: I needed you to be proud me, no matter how well I did at school. . . .

Kabir goes on to confront his father.

Therapist: . . . Well done, Kabir. How do you feel?
Kabir: A little better.
Therapist: Let's do one more thing. Imagine this chair holds Little Kabir. [*Introduces a second chair*].

(*The therapist creates an emotive impression of Kabir's child self*).

Therapist: Here is the small child who worked so hard but was always criticised by his family. [*Gestures to the second empty chair*]. How do you imagine he is sat over there?
Kabir: He's slouched over.
Therapist: How do you imagine he's feeling?
Kabir: He's feels ashamed. He thinks he's let his family down.
Therapist: What does he need right now?
Kabir: To know he isn't a disappointment.

(*The therapist invites Kabir to meet the needs of his child self*).

Therapist: Can you say that to him?

Kabir: [*To empty chair two*]. You're not a disappointment. You're a good boy.

(*Repetition is used to build conviction in this new self-appraisal*).

Therapist: Again.
Kabir: [*Becoming tearful*]. You're a good boy.

(*The therapist prompts Kabir to soothe his child self*).

Therapist: Tell him what makes him a good boy. . . .

Kabir goes on to reassure and care for his child self. He then takes the seat of 'Little Kabir' to experience receiving this care.

If the client finds this procedure too demanding, therapists may choose to enact the adult self on their behalf – confronting the parent and soothing the child self – whilst they observe.

Note

1. Readers will notice an overlap between enactive rescripting and imagery rescripting (Arntz & Weertman, 1999).

23

Using chairwork to develop and consolidate positive core beliefs

Cognitive behavioural treatments often combine the re-evaluation of negative core beliefs with the consolidation of positive core beliefs. Research supports this guidance, linking positive self-appraisals to enhanced well-being (Lumley & McArthur, 2016). Chairwork not only provides an emotionally charged experience of positive schemata, but infuses these with authentic 'felt truth' (Chadwick, 2003; Meaden, Keen, Aston, Barton, & Bucci, 2013).

Developing positive beliefs

Chadwick (2003) has outlined a two-chair method for elaborating positive self-schemas. Because this intervention does not aim to modify negative core beliefs, it is particularly helpful when these self-appraisals are entrenched and resistant. To begin, the client describes their experience of the negative core belief in chair one. Next, autobiographical events reflecting positive experiences of the self are used to develop a positive self-belief in chair two. Finally, the client and therapist reflect on how both experiences of the self are valid and authentic. Chairs are placed in parallel during this exercise to avoid dialogue between the core beliefs. This ensures the negative schema is unable to overrun its fledgling counterpart.

Jane is describing the lived experience of her core belief, 'I am worthless' (chair one).

Therapist: Let's start by exploring this sense of worthlessness.

(*The therapist reframes Jane's negative core belief as an experience of her self; not her actual self*).

Therapist: How do you experience yourself when this belief is active?
Jane: I feel unimportant, like a piece of dirt.

(*The therapist highlights the fixed and global nature of Jane's core belief*).

Therapist: Do you experience your self as completely worthless as a person, or just a part of you?
Jane: All of me.
Therapist: How do you perceive other people in these moments?
Jane: I feel like they don't care about me or notice me.
Therapist: And does it seem this experience of your self and others will ever change?
Jane: [*Becomes tearful*]. No. It's who I am and who I'll always be.

(*Jane's tears suggest her negative core belief is now active; further exploration is unnecessary*).

Therapist: Change seats. [*Jane moves to chair two*].

(*The therapist assists Jane in decentring from her negative core belief*).

Therapist: I know this is difficult, but let's take a moment to set aside that belief and leave it in your first chair. . . . Now, I wonder if there have ever been times in life when you've experienced yourself as something other than worthless?

(*The therapist looks for even momentary exceptions*).

Therapist: Do you recall any moments like that, even if they were brief?
Jane: [*Thinking*]. . . . I remember feeling good at my surprise party last year.

(*Asking Jane to describe this memory in detail will help her connect with this positive experience of her self*).

Therapist: Take us back to that memory. What happened? . . .

Jane describes the memory in detail.

Therapist: . . . How did you feel seeing everyone at the party?
Jane: I was amazed! There were so many people smiling at me and hugging me!

(*The therapist now explores the implications of Jane's positive memory in terms of an alternative self-belief*).

Therapist: How did you experience your self in that moment?
Jane: I felt special, like I mattered.

(*The therapist creates a somatic anchor to Jane's positive schema*).

Therapist: How do you feel inside as you describe this experience of your self?
Jane: It's nice.
Therapist: Where do you feel that? What's it like?
Jane: It's a warmth across my chest.
Therapist: Take a moment to focus on that feeling. [*Jane closes her eyes*].
Jane: [*Smiling*]. It feels good.

(*Asking Jane to stand at this point establishes a metacognitive perspective on her core beliefs*).

Therapist: Can you stand with me? [*Both stand*]. This is interesting. I know much of the time you experience your self in this way – a seemingly worthless person whom no one cares about. [*Gestures to chair one*]. And yet over here is a different experience of your self – a person who is loved, cared about, and worthwhile. [*Gestures to chair two*].

(*The therapist highlights that both experiences of Jane's self are important and valid*).

Therapist: Both are real experiences for you, right? Both are true and valid.
Jane: Right.
Therapist: What do you make of that?
Jane: Perhaps I'm not completely worthless. I sometimes see myself differently. . . .

Positive self-beliefs can also be elaborated by soliciting the (positive) opinions of others. This might involve the client changing seats and enacting a loved one who does not support their negative core belief (Therapist: "Change seats and step into the shoes of

your best friend. . . . Speaking as this individual, would you agree Kabir is a failure? If not, how would describe him as a person? What events or experiences support this positive belief you hold about him?”).

Consolidating positive beliefs

Once positive core beliefs have been established, chairwork is used to elaborate and reinforce this ‘new way of being’. One approach involves exploring the client’s responses to real or hypothetical events from the perspective of their negative core belief (chair one) versus their positive core belief (chair two) (Meaden et al., 2013).

Jane is describing an upsetting event from the perspective of her ‘old system’/negative core belief (chair one).

Jane:	I was so upset when I saw the photos of my friends at the party without me.
Therapist:	In that moment, how did you understand not being invited?
Jane:	Perhaps no one wanted me there. Maybe they don’t like hanging out with me.
Therapist:	Then what did you do?
Jane:	I went to bed and cried. I did think about confronting them too. It was pretty nasty of them to exclude me like that.
Therapist:	Sounds like the ‘old system’ was really triggered by this situation, huh? [*Jane nods*]. Do you remember the new core belief that we’ve been developing?
Jane:	I’m a loveable person?
Therapist:	Right. How about we look at this situation through the lens of that ‘new system’?

(*Switching seats helps Jane decentre from her negative core belief*).

Therapist: Can you change seats? [*Jane moves to chair two*]. Let's leave 'old Jane' in your first seat [*nods to chair one*] and, over here, let's connect with 'new Jane'.

(*Embodiment is now used to immerse Jane in her 'new way of being'*).

Therapist: What posture goes with this new system?
Jane: What do you mean?
Therapist: If you believed that you were totally loveable, how would you be sitting in this chair? Maybe in an upright, self-assured way?
Jane: I guess.
Therapist: Try doing that. [*Jane sits upright*]. What about your facial expression?
Jane: Soft and relaxed.
Therapist: Maybe with a little smile? [*Jane nods*]. Give it a go. [*Jane relaxes and adopts a half-smile*]. Now, bringing to mind the belief, "I am a truly loveable person", let's review what happened last night.
Jane: I went online and saw my friends had gone to a party without me.
Therapist: How might 'new Jane' understand this?
Jane: [*Thinking*]. . . . Maybe there were other reasons why I wasn't invited.
Therapist: Such as?
Jane: [*Thinking*]. . . . Maybe they thought I was working yesterday. The party was also for someone I don't know.

(*Reinforcing the shift in Jane's perspective*).

Therapist: Makes sense, right? That would explain why they didn't invite you. [*Jane nods*].

(*The therapist now establishes a decentred perspective on Jane's 'old system'*).

Therapist: So when the 'old system' [*gestures to Jane's former chair*] pops up and says "they don't like me and want to hurt me", how would this 'new system' respond to that?
Jane: It would say my friends do like and care about me.

(*Contrasting Jane's 'old' versus 'new' ways of being*).

Therapist: And rather than sending them an angry message [*gestures to chair one again*], would 'new Jane' respond differently?
Jane: I'd ask if they had fun and see when we can meet up again. . . .

A final method for consolidating positive core beliefs, clients can be asked to role-play individuals who support their positive schemas. These individuals might include persons from the past (e.g. a compassionate caregiver), the future (e.g. the client's grown children), fictitious individuals such as the client's 'perfect nurturer' (Lee, 2005), or their 'Compassionate Self' (Gilbert, 2010).

Therapist: How much do you believe this new belief, "I am a successful person"?
Kabir: About 20%.

Therapist: Is there anyone who might think of you as more than 20% successful?
Kabir: I have no idea.
Therapist: Does Gina, your daughter, see you as just 20% successful as her father?
Kabir: I hope not!

(*Chairwork is used to help Kabir see himself from the adaptive, interpersonal perspective of his daughter*).

Therapist: Let's see. Imagine Gina were sat here. [*Introduces a chair*]. Can you come over and enact her for a moment? [*Kabir switches seats*].

(*The therapist concretises this new perspective by addressing Kabir as 'Gina'*).

Therapist: Nice to meet you, Gina! Tell me, what do like about your dad? What does he do well?
Kabir: [*As Gina*]. I like it when he reads me bedtime stories.
Therapist: Does he read them 20% well?
Kabir: He reads them 100% well!

(*The therapist takes this opportunity to elicit further evidence which supports Kabir's positive self-belief*).

Therapist: What else does your dad do well? . . .

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Using chairwork to resolve ambivalence and enhance motivation

Ambivalence about change is associated with poorer outcomes in action-focused therapies (Westra & Norouzian, 2018). To improve engagement and therapeutic outcomes, CBT has sometimes been combined with motivational interviewing (MI; Miller & Rollnick, 2013); an integration which has produced positive outcomes (Marker & Norton, 2018). Experiential interventions such as chairwork provide an additional means to resolve ambivalent attitudes and strengthen commitment to change (Pugh & Salter, 2018).

Therapist stance

Therapists' style of facilitation requires some consideration when using chairwork to address ambivalence. A more active, directive manner of facilitation is generally recommended when addressing indecision in the context of psychopathology (e.g. ambivalence regarding substance misuse). In these circumstances – and consistent with MI – therapists aim to elicit and selectively reinforce change-talk during motivational chairwork, whilst simultaneously 'rolling with' counter-change-talk. However, if ambivalence is unrelated to psychopathology (e.g. uncertainty regarding innocuous life choices), a more impartial, facilitative stance is recommended.

Assessing readiness to change

Clients' attitudes towards change are assessed using chair-based representations (CRIB) (Pugh, 2019). This intervention involves the client placing a chair, symbolising the focus of their ambivalence,

somewhere in the room which reflects its significance: the closer this chair is to the client's seat, the more important the subject/object of ambivalence is. This exercise can then be taken in different directions, as the following transcript illustrates.

Jane is exploring her attitudes towards recovery from her eating disorder.

Therapist: Imagine this chair represents anorexia. How close is it to you right now?
Jane: Very close, about here. [*Places the chair an inch from her own*].

(*Jane clearly has some attachment to her eating disorder*).

Therapist: It's really important, huh? [*Jane nods*]. What are the good and bad sides of having anorexia so nearby all of the time?
Jane: Life's simpler. I don't have to worry about going to college when I'm unwell. I also have something to think about so I don't feel lonely.
Therapist: And the bad sides?
Jane: [*Thinking*]. . . . I guess I don't have energy for much else.

(*The therapist uses a change in spatial perspective-taking to tentatively highlight the potential advantages of change*).

Therapist: What if we moved anorexia a little further away? [*Moves the chair a few feet from Jane*]. Would that have advantages or disadvantages?
Jane: I'd have more room to breathe!

Therapist: Would that create space for something else, something good?
Jane: Maybe I'd have the strength to see my friends.

(*The therapist concludes by elaborating concrete behavioural changes Jane might consider implementing*).

Therapist: So if creating distance from anorexia seems helpful, how could you begin that process? . . .

Resolving ambivalence

Two-chair decisional balancing is an experiential approach to costs-benefits analysis (Arnkoff, 1981; Kellogg, 2015). Starting with whichever side feels strongest, the client is asked to present their reasons for and against change from different chairs. They then move between these seats, responding and counter-responding from both perspectives, until ambivalence is more resolved. Towards the end of the dialogue, the client is asked to stand and reflect on their feelings towards each side. If feeling more decided at this point, chairwork concludes with the client selecting one of the chairs and explaining their reasons for this choice.

Jane is exploring her attitudes towards recovery from anorexia nervosa.

Therapist: Which side feels strongest right now – the side which wants to change your eating disorder [*gestures to chair one*] or the side which doesn't [*gestures to chair two*]?
Jane: The side that doesn't want to change.

(*The therapist 'rolls' with Jane's counter-change-talk*).

Therapist: Take a seat in that chair. [*Jane switches to chair two*]. So what are your reasons for not wanting to change? "I want to stay as I am because". . . .

Jane: Anorexia gives me a sense of achievement. I'm proud of my weight loss. Not everyone can do that.

(*The therapist comes alongside Jane's sustain-talk*).

Therapist: Anorexia makes me feel special.

Jane: Yeah. It makes me different.

(*The therapist amplifies Jane's sustain-talk to elicit change-talk*).

Therapist: And being different is the most important thing to me.

Jane: Well, not really. I actually feel uncomfortable when people comment on how thin I am.

(*Jane's emotional reactions are used to generate further change-talk*).

Therapist: How do you feel as you talk from this side?

Jane: [*Thinking*]. . . . Pretty empty. All I ever do is think about food and my weight. It's not much of a life.

(*The therapist seizes this opportunity to hear more from Jane's 'change side'*).

Therapist: Sounds like the other side is coming out now. Can you switch? [*Jane moves to chair two*].

(*The therapist feeds Jane a line to elicit further change-talk*).

Therapist: So this side thinks, "I want to change because life with anorexia feels empty". Is that right?
Jane: Yeah. Life's so boring when everything revolves around food.

(*Affirming change-talk*).

Therapist: I can understand why you get tired of that.

(*Elaborating change-talk*).

Therapist: What else does this side think? What other problems come with anorexia? . . .

Jane goes on to speak from both chairs until her attitude towards recovery seems more resolved.

Therapist: . . . Now we've heard from both perspectives, let's stand. [*Jane and her therapist stand*]. How do you feel towards these sides of your self? [*Gestures to the 'change' and 'sustain' chairs*].
Jane: I was definitely in favour of that side before we started [*gestures to the 'sustain' chair*], but now I'm leaning more towards this one [*gestures to the 'change' chair*].

(*The therapist assesses the degree of change in Jane's ambivalence*).

Therapist: How would you rate the relative strength of each side now? 50–50?
Jane: 80% in favour of changing.

(*The therapist takes this opportunity to strengthen Jane's commitment to change*).

Therapist: In that case, take a seat in the chair representing change. [*Jane moves to chair one*]. Can you try state your reasons for favouring this seat? [*Emphasising choice and responsibility*]. "I'm choosing change because". . . .

Jane goes on to outline her reasons for recovery.

Sometimes ambivalence is grounded in fears about change. In this case, dialogues between the client's 'emotional side' ("I'm scared about giving up my safety behaviour") and 'rational side' ("I need to learn to cope without my safety behaviour") may be a more appropriate means to encourage decision-making ('consensual role-plays'; de Oliveira, 2015).

Ambivalent attitudes can also be explored through 'vector dialogues' (Kellogg, 2017). A triangular formation of three chairs is used here. To begin, the subject/object of ambivalence is placed in an empty seat (chair one). Starting with the stronger side, the client then expresses their positive attitudes towards the subject/object (chair two) followed by their negative attitudes (chair three). Once these have been fully expressed, chairwork concludes with the client formulating a decision about how the relationship with the subject/object will change, if at all.

Kabir has started a vector dialogue with his alcoholism.

Therapist: Now we've placed alcohol in the empty seat [*gestures to chair one*], which side shall we begin with – the part of you which feels positively towards drinking or negatively?

Kabir: The side that's grateful for alcohol.

(*Rolling with Kabir's sustain-talk*).

Therapist: Let's start in that chair. [*Kabir moves to chair two*].

(*Prompting Kabir to speak directly to 'alcohol' heightens his immersion and emotion*).

Therapist: From here, tell alcohol what you're grateful for. [*Gestures to empty chair one*].
Kabir: [*To the chair holding 'alcohol'*]. I'm grateful for the confidence you give me when I socialise. . . .

Kabir outlines his positive feelings towards alcohol.

Therapist: . . . How do you feel as you describe what alcohol has done for you?
Kabir: Sad, really. Alcohol hasn't solved any of my problems. It's made them worse.

(*The therapist capitalises on Kabir's emerging change-talk*).

Therapist: Switch then. [*Kabir moves to chair three*]. Speak from your sadness, Kabir. Tell alcohol about the negative feelings you hold towards it. . . .

Kabir outlines his negative feelings towards alcohol.

'Future selves' dialogues (Pugh & Salter, 2018) are used to examine the longer-term implications of current attitudes and behaviours. This exercise involves the client embodying two versions of their self. First, a 'future self' which embodies the implementation of decision A is enacted (e.g. "My future self as if I were still using

drugs"). Next, the client embodies a different future self as if decision B had been implemented (e.g. "My future self as if I had stopped using drugs"). Each future self is interviewed by the therapist regarding how their life has unfolded in key domains (e.g. health, relationships, finances, etc.). After these enactments, chairwork concludes with the client reflecting upon which 'future self' seems most appealing and consistent with their values.

Therapist:	Imagine your self in this chair as if you still had anorexia in ten years' time. [*Introduces chair one*].

(*Jane is guided in developing an evocative, multisensory impression of this 'future self'*).

Therapist:	How you picture this version of Jane?
Jane:	She looks tired and frail.
Therapist:	What do you imagine she's feeling?
Jane:	Numb. . . . But deep down she's lonely.
Therapist:	How would she sound?
Jane:	Pretty quiet and weak, I guess.
Therapist:	Why don't we get to know this version of Jane a little better. Can you change seats and be this future self? [*Jane moves to chair one*].

(*Addressing Jane 'as if' ten years have passed helps to immerse her in this role*).

Therapist:	Nice to see you again, Jane. How have you been these last ten years?
Jane:	Not great. I'm still unwell.
Therapist:	Sorry to hear it. What's that like for you?
Jane:	Pretty crappy. My osteoporosis is worse. I haven't seen my friends in years. My family have given up on me. [*Becomes tearful*]. . . .

Jane goes on to describe daily life for this future self in other domains.

Therapist: . . . Life sounds tough, Jane.

(*The therapist attempts to elicit change-talk by asking Jane's 'future self' to advise her 'past self'*).

Therapist: If you could go back in time and speak to your self when you were contemplating recovery, what advice would you give? [*Gestures to Jane's original chair*].
Jane: [*To the empty chair*]. Living with anorexia is miserable, Jane. You need to get better.

(*Repetition is used to reinforce and build conviction in Jane's change-talk*).

Therapist: Say that again.
Jane: You need to get better.
Therapist: Come back to your first seat. . . .

Jane reflects on the experience of embodying her future, non-recovered self before moving on.

Therapist: . . . Let's imagine recovered Jane in this other seat. [*Introduces chair two*]. How do you picture this self?
Jane: I see a strong, self-assured woman.
Therapist: How you imagine she feels?
Jane: She's happy.
Therapist: Can you step into her shoes? [*Jane moves to chair two*].

(*The therapist uses an upbeat and energetic tone of voice to help align Jane with this more favourable 'future self'*).

Therapist: Great to see you, Jane! I can't believe it's been ten years. How are you?
Jane: [*Smiling*]. Great! I'm married, I'm running my own store, I even have children.
Therapist: That's fantastic!

(*Jane clearly prefers her 'future-recovered self'! The therapist takes this opportunity to reinforce the decision to change*).

Therapist: Last time we spoke you felt unsure about moving on from anorexia. How did you feel about your decision now?
Jane: I'm so glad I did. . . .

Strengthening commitment

'Decision dialogues' aim to strengthen commitment to change (Goulding & Goulding, 1979). This enactment invites the client to present their reasons for change directly to the subject/object of their ambivalence, represented by an empty chair. This statement might also include a summary of why the problem arose, the difficulties it has caused, and the steps that will be taken to bring about change.

Kabir has decided to stop drinking. His therapist has proposed a decision dialogue.

Therapist: Let's start by imagining alcohol in the empty chair. [*Gestures to the empty seat*]. What do you see?

Kabir: I see a bottle of whiskey.

Therapist: Why don't you start by telling alcohol about why it came into your life and how it became a problem?

Kabir: You came into my life because I felt anxious socialising. Initially you helped me feel confident but then you took over. . . .

Kabir goes on to describe problems his alcoholism has caused.

Kabir: . . . I can't continue with you in my life.

(*The therapist prompts Kabir to use decisive language regarding change*).

Therapist: Tell alcohol what you've decided.

Kabir: I'm not drinking anymore. You need to go.

(*How 'alcohol' responds to this statement will probably say something about Kabir's confidence in changing*).

Therapist: How does alcohol respond to that? [*Gestures to the empty chair*].

Kabir: [*Thinking*]. . . . It says I'm too weak to change.

(*The therapist builds Kabir's confidence by bringing attention to his strengths and the concrete steps for initiating change*).

Therapist: Tell alcohol what's going to sustain your strength and how you're going to begin changing this relationship. . . .

Playing 'devil's advocate' is another well-known technique for strengthening commitment (see Chapter 18 for further details). In summary, this intervention involves the therapist presenting reasons

against change (chair one) whilst the client argues in favour of change (chair two). It should be noted that therapist-led coaching is not provided if the client struggles to counter-argue during this exercise – this risks eliciting counter-change-talk (Burns, 2018b). Rather, 'stuckness' suggests the client's ambivalence has not yet been resolved and commitment-focused interventions have been introduced prematurely.

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Using chairwork to develop compassion for the self and others

Developed for the treatment of emotional disorders where shame and self-criticism are pronounced, compassion focused therapy (CFT) aims to cultivate sensitivity for the suffering of the self and others combined with a motivation to alleviate and prevent that suffering (Gilbert, 2017). CFT was originally inspired by the observation that some individuals experience the alternative thoughts generated in CBT as cold and hostile. Accordingly, CFT seeks to develop patterns of thought and feeling which possess a kinder and more encouraging emotional texture (Gilbert, 2010). Chairwork represents a core experiential method for building this 'compassionate mind' in CFT, thereby shifting individuals from a threat-based mindset and towards a care-based motivation and mentality.

Compassion for others (empty-chairwork)

Emphasis is placed on strengthening the 'Compassionate Self' in CFT. Empty-chair techniques are initially used to establish this compassionate perspective by cultivating compassion for others (Kolt, 2016). As the following transcript illustrates, many clients benefit from quite detailed guidance when first embodying and developing the motivations of the Compassionate Self. In addition, these immersive embodiments will also provide a valuable anchor to the Compassionate Self in later sessions (Bell et al., in review).

Kabir: I feel so ashamed of myself. Why do I get so anxious when I present?
Therapist: Perhaps your Compassionate Self could help with this. Can we try an exercise?
Kabir: Ok.

(*The therapist guides Kabir in embodying key aspects of the Compassionate Self: commitment, wisdom, and strength*).

Therapist: Let's begin by connecting with your Compassionate Self. Close your eyes and find your soothing rhythm of breathing. . . . Adopting an expression of non-judgemental care. . . . Imaging your body filling with a motivation and commitment to be compassionate to your self and others. . . . Seeing life through the wise, courageous eyes of the Compassionate Self. . . . Do you feel in touch with that part?
Kabir: . . . I do.
Therapist: Great. Now imagine that this seat holds someone you would want to help if they were suffering. [*Introduces a chair*].
Kabir: My daughter?
Therapist: Perfect. Picture your daughter sat there, except imagine that she's feeling ashamed. Perhaps she's given a presentation at school and feels really bad for getting anxious.

(*The therapist encourages Kabir to connect with the emotional dimensions of compassion*).

Therapist: If she shared this with you, how would you feel towards her?
Kabir: I'd feel bad for her.

Therapist: Would you blame her for her anxiety?
Kabir: No way. Everyone feels anxious sometimes.

(*Bringing attention to compassion as a motivation*).

Therapist: From this position of compassion, what would you want for her?
Kabir: I'd want her to be happy. She doesn't deserve to suffer.

(*Bringing attention to compassion as an understanding*).

Therapist: What would your Compassionate Self want her to know and understand?
Kabir: She was brave for presenting. Anxiety is an understandable reaction in that situation. It's nothing to be ashamed of.
Therapist: How do you imagine she'd feel hearing that?
Kabir: Better, I hope.

(*The therapist contrasts Kabir's Compassionate Self with his threat-focused mindset*).

Therapist: So, here we have two very different ways of understanding and responding to anxiety. One perspective is wrapped up in criticism, whilst the other offers acceptance and encouragement.

(*The therapist uses guided discovery to explore whether Kabir feels self-compassion might benefit his struggles*).

Therapist: Which of these approaches do you think would help develop your confidence in social situations?
Kabir: The second one. . . .

Compassion for the self (two-chairwork)

Later in CFT, chairwork is used to facilitate dialogues between clients' distress (i.e. their 'Vulnerable Self') and their Compassionate Self. These two-chair methods enable clients to express, experience, and deepen self-directed care and validation in the present moment (Kolt, 2016).

Therapist: So far we've looked at developing compassion through letter-writing and imagery. Perhaps we could use the chairs to bring that process more to life?

Kabir: Sure.

(*The therapist helps Kabir connect with his distress by embodying his 'Vulnerable Self'*).

Therapist: Let's begin by placing 'Sad Kabir' in this seat. [*Introduces a second chair*]. I know this week has been tough, Kabir. I imagine it's brought up considerable pain for your Sad Self. Can you switch chairs and speak as that part? [*Kabir moves seats*]. What is Sad Kabir thinking and feeling right now?

Kabir: [*As the Sad Self*]: Receiving the divorce papers from my wife has been awful. I miss her so much. [*Becomes tearful*]. I don't want lose her. . . .

Kabir describes thoughts, feelings, and motivations linked to his Vulnerable Self. He then returns to his original chair and embodies his Compassionate Self.

Therapist: . . . Do you feel connected with your Compassionate Self? [*Kabir nods*]. Let's turn our

attention to Sad Kabir then. This side is feeling a lot of pain and loss right now. [*Gestures to the empty seat of Vulnerable Self*]. Looking at what's been happening for Kabir from this compassionate perspective, do his feelings make sense?

Kabir: They do. It's hard separating from someone you care so much about.

Therapist: Understanding that suffering, how do you feel towards him?

Kabir: I feel bad for him. He just wants to be loved and accepted.

(*Kabir is now prompted to dialogue with his Vulnerable Self from the perspective of his Compassionate Self*).

Therapist: Try talking to Kabir from this compassionate viewpoint. [*Gestures to chair one*]. What support and guidance can you offer him? . . .

This exercise usually concludes with the client moving back into the chair of their Vulnerable Self and experiencing self-directed compassion. Note that Kabir has brought a single emotion to chairwork in this example (i.e. sadness). If several emotions were to arise, therapists utilise 'multiple selves' dialogues to bring compassion to all of these affective states (see below).

An alternative two-chair method, dialogues between the Critical Self and the Compassionate Self are also facilitated in CFT. This can help soothe and bring understanding to the inner critic, its intentions, and underlying feelings of vulnerability (Kolt, 2016). However, should the inner critic reflect the internalised voices of abusive persons, or seeks to harm the client, a more assertive approach is employed (Gilbert, 2010). This might involve the Compassionate Self (enacted by client in chair one) holding the abuser accountable

for wrong-doing (represented by empty chair two). Supportive coaching is provided by the therapist in chair three (Bell, 2019). The exercise ends with the Compassionate Self providing care to the client's Criticised Self or their traumatised Child Self (chair four). Used in this way, the Compassionate Self can function as a 'secure base' for engaging in challenging dialogues with threatening others (Paul Gilbert, personal communication).

Compassion for the 'critical' and 'criticised' selves (three-chairwork)

Three-chair dialogues between the Critical Self, Criticised Self, and Compassionate Self are centralised in CFT. In these exercises, emphasis is placed on acknowledging, understanding, and bringing compassion to polarised critical and criticised parts of the client. Note that, unlike CBT and ST, these dialogues do not challenge, eject, or 'soothe away' self-criticism. Rather, they aim to strengthen the compassionate mind to address the threats and fears underlying self-attacking (Gilbert, 2010). A triangular formation of chairs is used in this form of chairwork.

Jane has been criticising herself for binge-eating. She has enacted her self-criticism by speaking as the 'Critical Self' (chair two) and then experiencing how this is felt by her 'Criticised Self' (chair three) (see 'two-chair enactments'; Chapter 21). She now returns to her original chair (chair one) to embody the Compassionate Self.

Therapist: Let's see what the Compassionate Self makes of what's happening between the critical and criticised parts of your self. Can you come back to your original seat? . . .

Jane switches into her first chair and embodies her Compassionate Self.

Therapist: . . . From this compassionate perspective, how do you understand the criticised part of Jane feels? [*Gestures to chair three*].
Jane: She feels worthless. She's trying to eat more but it's hard not to slip into binge-eating.

(*Jane now explores the motivations of the Critical Self from a compassionate perspective*).

Therapist: And what's this critical side trying to do? [*Gestures to chair two*].
Jane: It's trying to keep Jane on track, but it gets frustrated when she overeats.

(*The therapist deepens Jane's understanding for the Critical Self*).

Therapist: Why do you think the critical side gets so upset when that happens?
Jane: [*Thinking*]. . . . Because it's scared no one will like her if she overeats or gains too much weight.
Therapist: Then it puts her down? [*Jane nods*].
Therapist: What's that like for Jane? Does it help?
Jane: No, it makes her feel worse.

(*Jane is now encouraged to express compassion and understanding for her Critical Self*).

Therapist: From this compassionate perspective, what do you want the critic to understand? [*Gestures to chair two*].

Jane: [*To chair two*]. I know you're trying to help and I understand you're frightened that people might not like Jane if she gains too much weight.

(*The therapist affirms the insights of Jane's Compassionate Self*).

Therapist: Right. There's a fear driving this critical side. The way its reacting makes sense.
Jane: Exactly. No one wants to be rejected. It's scared for Jane. At the same time, putting her down only makes her feel worse. She needs support.
Therapist: So what do you want for the inner critic? Tell it.
Jane: [*To chair two*]. I want you to feel safe and happy.
Therapist: How about the criticised side of Jane? [*Gestures to chair three*]. What do you want the part of her that's suffering to understand?
Jane: [*To chair three*]. You're not worthless. You're working so hard. Change is difficult but don't give up.
Therapist: Well done, Jane.
Jane: Thanks. I feel better.

(*Bringing attention to metacognitive aspects of the Compassionate Self*).

Therapist: It was great seeing your Compassionate Self step back from the battle between the Critical Self and Criticised Self, then deciding what's going to be best for both these parts of you. There's a real wisdom in your Compassionate Self. . . .

Multiple 'emotional' selves (multi-chairwork)

'Multiple selves' aims to help clients differentiate, explore, and respond compassionately to their emotional experiences. This multi-chair exercise invites the client to speak from the perspective of key threat-based emotions (the 'Angry Self', 'Anxious Self', and 'Sad Self') and connect with the core dimensions of these affective states including associated thoughts, memories, somatic sensations, and behavioural motivations. In doing so, clients learn that these emotions are comprehensible, tolerable, and organise the mind in distinctive ways.

Therapist: Your mother's comments about looking healthier stirred up lots of feelings, huh? [*Jane nods*]. Which emotion feels strongest right now?

Jane: I feel really anxious. What did she mean when she said I looked better?

Therapist: Can you move into the chair for Anxious Self? [*Jane moves to chair one*].

(*Jane connects with her Anxious Self by first exploring the most salient [i.e. somatic] features of her anxiety*).

Therapist: As Anxious Self, where do you feel that nervousness?

Jane: It's a tight feeling, here. [*Touches chest*].

(*Intensifying the somatic aspects of the Anxious Self helps Jane immerse herself in this self-experience*).

Therapist: Allow that feeling to grow and fill your body if you can, Jane.

(*Bringing attention to cognitions associated with the Anxious Self*).

Therapist: Can you put words to that tightness? What does Anxious Self have to say?
Jane: What was mum getting at when she said I looked healthier? Am I gaining too much weight? Does she think I'm fat?
Therapist: What tone do those thoughts have?
Jane: They're desperate.

(*Bringing attention to the behavioural motivations of the Anxious Self*).

Therapist: If Anxious Self were in complete control, what would it want to do?
Jane: I just want to stop eating.

(*Jane explores memories associated with the Anxious Self to clarify its origins*).

Therapist: What memories go with Anxious Self?
Jane: [*Thinking*]. . . . It reminds me of gym class at school. I felt so self-conscious changing into my kit. I always thought the other girls were judging my body.

(*Now more familiar with the process of 'multiple selves', Jane is asked to embody a more threatening emotional self*).

Therapist: We've gotten to know Anxious Self better, but I wonder what Angry Self feels about this situation. Can you change seats? [*Jane moves to chair two*]. Let's thank Anxious Self for talking with

	us [*nods to chair one*] and connect with Angry Self. Looking back at your mum's comment, does any anger come up?
Jane:	[*Thinking*]. . . . Actually, yeah. Why can't she just keep her opinions to herself? . . .

Multiple selves can be taken in different directions at this point. Towards the end of the exercise, the Compassionate Self might be invited into the dialogue to validate and manage each emotional self (Therapist: "As the Compassionate Self, want do you want to say to each of these emotions?"). Conflicts between emotional selves can also be explored (Therapist: "What does Angry Self think of Anxious Self?"), as can the clients' relationship with each self (Therapist: "Which self is most familiar? Which is hardest to acknowledge? Which needs more space to be heard?"). Finally, the Compassionate Self's response to the distressing event can be elaborated and contrasted with those of the emotional selves.

Fears, blocks, and resistances to compassion

Cultivating compassion is not always easy. Many individuals who enter therapy fear, doubt, or oppose compassion for the self, for others, or from others (Gilbert, McEwan, Matos, & Rivis, 2011). Consequently, they may resist compassion-focused interventions or experience limited therapeutic gains. Bell (2019) suggests these fears, blocks, and resistances to compassion can be resolved through chairwork in the following ways:

- Ambivalent attitudes towards compassion are clarified and resolved through two-chair decisional balancing (see Chapter 24).

- Intrapersonal role-plays allow therapists to clarify the origins, functions, and manifestations of FBRs. As described in Chapter 21, this involves the client changing seats and speaking as the fear/block/resistance during simulated interviews with the therapist.
- Two-chair dialogues between the Compassionate Self (chair one) and FBRs (chair two) are used to validate resistance to compassion. As the dialogue progresses, the Compassionate Self gently negotiates access to the client's Vulnerable Self (chair three).

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Using chairwork to modify schema modes

Schema therapy (ST) integrates elements of cognitive, behavioural, experiential, and psychodynamic therapy. ST posits that psychopathology is grounded in maladaptive 'schemas' (trait-like cognitive-affective patterns developed in childhood) and associated 'modes' (dynamic, state-like constellations of thought, feeling, and behaviour). Experiential interventions such as chairwork are regarded as being a particularly effective means to stimulate schematic change (Young et al., 2003). Schema-focused chairwork techniques are described in Chapter 22. Accordingly, this chapter focuses on mode-focused dialogues.

Combating parent modes

Parent modes such as the 'demanding' and 'punitive' mode tend to manifest as self-criticism and self-loathing. Therapists initially use chairwork to confront these distressing modes on behalf of the client (Arntz & Jacob, 2013; Young et al., 2003). This combative style of dialogue is markedly different to compassion-focused (chapter 25) and emotion-focused chairwork (Chapter 28), and is particularly useful when self-criticism represents the voices of past abusers. Three-chair dialogues between the vulnerable child mode, the punitive parent mode, and the healthy adult mode will often be utilised during the early stages of ST, as the following transcript illustrates.

Kabir: I got the kids to school late again. [*Sighs*]. I'm such an incompetent father.

(*Kabir's self-criticism suggests that his punitive mode is activated*).

Therapist: It sounds like your punitive mode is giving you a hard time. [*Kabir nods*]. [*The therapist introduces two chairs, forming a triangle with Kabir's own seat*]. Can you switch seats and speak as that mode? [*Kabir switches to chair two*]. What is it saying?

Kabir: [*Addressing his original chair as the punitive mode*]. You're an awful father and let everyone down. No wonder your wife left you.

(*The therapist assesses the emotional impact of these self-attacks*).

Therapist: Can you move to the third chair for Little Kabir? [*Changes to chair three*]. How does your vulnerable part feel when you're attacked like that?

Kabir: [*Becomes tearful*]. It hurts. Why do I always mess up?

(*The therapist models the healthy adult mode by confronting Kabir's punitive mode*).

Therapist: Can I speak to your punitive mode as the heathy side?

Kabir: Ok.

(*The therapist addresses the punitive mode in authoritative manner. The therapist does this from Kabir's original seat to encourage internalisation of the healthy adult mode*).

Therapist: [*Moves to chair one – Kabir's original seat – and addresses the punitive mode's empty chair*]. Stop putting Kabir down! He's a good father and doesn't deserve this abuse. Be quiet unless you have something helpful to say!

(*The therapist assesses whether 'Little Kabir' has experienced confrontation as therapeutic*).

Therapist: [*Turns to Kabir*]. How does that feel?
Kabir: A little better. . . .

(*Spatial perspective-taking is now used to concretise ejection of the punitive mode*).

Therapist: Would it help if I put the punitive mode's chair outside?
Kabir: Yes please. . . .

Note that the therapist does not challenge the punitive mode whilst Kabir is enacting this self-part. This is important: therapists only challenge the punitive mode in an empty chair so that the client does not feel confronted themselves.

As therapy progresses, clients learn to confront their parent modes more independently. This is usually scaffolded in three phases. Initially, clients are encouraged to confront their parent modes from a position of anger (i.e. speaking from the perspective of their 'angry child' mode) (Therapist: "As Angry Kabir [*chair one*], tell the demanding mode [*empty chair two*] why it's unfair and unhelpful"). Later, clients might respond to their parent modes as if they were defending a loved one (i.e. speaking from their 'healthy adult' mode) (Therapist: "What would you say to this mode if it were criticising your daughter?"). Lastly, direct dialogues between

clients' healthy adult mode (chair one) and parent modes (chair two) are facilitated.

Healing child modes

Child modes usually manifest as fear (the 'vulnerable child' mode), sadness ('lonely' or 'abandoned' child modes) or frustration ('angry child' mode). Angry child modes, which are often silenced in childhood, are often encouraged to 'vent' at antagonists using empty-chair techniques. When vulnerable child modes emerge, therapists use chairwork to help clients connect with these emotions and soothe their distress (a process termed 'limited reparenting').

Previous transcript continued. . . .

Therapist: [*Remaining in the healthy adult's seat*]. Now we've spoken to the punitive mode, I'd like to check in with Little Kabir. How are you feeling right now?

Kabir: [*Remaining in the vulnerable child's chair*]. I'm so sorry I let my kids down. [*Begins crying*].

(*The therapist soothes and reparents Kabir's vulnerable child mode from the perspective of the healthy adult mode*).

Therapist: [*In a soothing tone of voice*]. I know, Kabir. It hurts when things go wrong. [*Kabir nods*]. Your children are so lucky to have a father who cares as much as you do. . . .

Clients reparent their child modes from the perspective of their healthy adult mode in the later stages of therapy. Two-chair techniques are used to facilitate this process (see 'two-chair self-soothing'; Chapter 19).

Bypassing coping modes

Coping modes manage the distress arising from schema activation. These modes often reflect adaptions to childhood environments in which the client's emotional needs were unmet (Young el al., 2003). Unfortunately, coping modes tend to reinforce schemas in later life and can obstruct therapy, such as by preventing access to the client's child modes. Accordingly, schema therapists use chairwork to confront and 'bypass' these self-parts. This differs from EFT, wherein client's adaptive, affective reactions are used to address these blocks (see Chapter 28).

Schema therapists use intrapersonal role-plays to explore the functions and developmental origins of coping modes (see Chapter 21). During these dialogues, therapists balance validation of the coping mode with empathic confrontation regarding their negative consequences. This helps clients acknowledge the disadvantages of their coping modes without eliciting defensive reactions (Arntz & Jacob, 2013).

Therapist: I'd like to get to know your detached protector mode better. Can you switch chairs and speak from that perspective? [*Jane switches*].

(*To avoid defensiveness, the therapist speaks to Jane's coping mode in a friendly tone*).

Therapist: Thanks for speaking with me, detached protector. What's your role in Jane's life?
Jane: [*As the detached protector*]. I stop her feeling.

(*The therapist explores the aetiology of this mode*).

Therapist: When did you start doing that for her?

Jane: When she was small. Her mum was really mean back then.

(*The therapist validates the historical functions of the coping mode*).

Therapist: So you helped her cope with that pain as a child? [*Jane nods*]. I'm glad you were there to do that for her.

(*Jane now looks visibly more relaxed in the role of the detached protector*).

Therapist: As an adult, what's it like for Jane when you stop her feelings?
Jane: She feels empty.

(*The therapist hypothesises that these feelings of emptiness are probably causing Jane some difficulty and so brings attention to these costs*).

Therapist: Does she feel anything else?
Jane: [*Silent*]. . . . Sometimes she feels lonely.

(The therapist gently confronts the coping mode).

Therapist: I can understand why it's lonely for her sometimes. It must be hard for her to connect with people and get the care she needs when she feels empty. . . .

Two-chair dialogues incorporating child modes are also used to highlight the detrimental effects of coping modes. Here, therapists confront coping modes by bringing attention to the pain child modes experience as a result of dysfunctional coping styles.

Therapist: You seem cut off today, Jane.
Jane: [*Shrugs*]. Maybe.
Therapist: Perhaps your detached mode is active?
Jane: I guess.

(*The therapist hypothesises that Jane's detached mode has been precipitated by some kind of emotional distress*).

Therapist: I might be wrong, but I wonder if there's some difficult feelings beneath that detachment? [*Jane shrugs again*].

(*Jane's detached mode seems entrenched. Switching chairs encourages her to 'step out' of this mode*).

Therapist: Let's try something. Imagine this chair holds the detached mode [*introduces chair one*] whilst this chair holds Little Jane, the part which feels [*introduces chair two*]. Can you move to the protector's chair? [*Jane moves to chair one*].

(*The therapist asks Jane to enact the process of detachment*).

Therapist: Be the protector and tell Little Jane why she mustn't feel. [*Gestures to chair two*].
Jane: [*As detached protector*]. Push the emotions away. Cut off from the pain.

(*Speaking as her vulnerable child mode now connects Jane to her emotions and affective responses to the process of detachment*).

Therapist: Come over to the emotional side. [*Jane moves to chair two*]. How does that make Little Jane feel?

Jane: [*Silent*]. . . . I'm hurting inside. . . . If I pretend I'm ok, nobody can help me.

(*Jane is encouraged to confront the coping mode by directing this response to the detached protector's chair*).

Therapist: Say that to the detached mode. [*Gestures to chair two*]. "I need you to let me feel so I can be helped". . . .

Therapists also use empty-chairwork to bypass coping modes. These dialogues are often brief and so are especially useful when coping modes 'pop up' during the session. Again, therapists balance validation and confrontation during these dialogues with coping modes.

Therapist: A moment ago you seemed upset, but now I sense you're holding those feelings back.
Jane: Maybe a little.

(*The abrupt reduction in Jane's emotional expression suggests her detached protector is active. An empty chair is now used to empathically confront this mode*).

Therapist: Would it be ok if I spoke with your detached mode, as if it were sat here? [*Introduces a chair*].
Jane: Ok.

(*The therapist opens the dialogue with appreciation and validation, before moving onto confrontation*).

Therapist: [*To the empty chair*]. Thanks for letting me speak with you, protector. I know there are good

reasons why you're active today. Jane has had such an upsetting week. However, I'd really like to continue speaking with the part of her that's suffering.

(*The therapist reassures Jane's coping mode to encourage it to weaken*).

Therapist: If you'll let me do that, I'll make sure her emotions won't overwhelm her. I just want to help take care of that pain. [*Turns to Jane*]. Can we try that, Jane?

Jane: Ok. [*Becoming tearful*]. It's just hard for me to show my feelings.

Therapist: Let the tears come, Jane. [*Jane starts crying*]. I'm here for you. . . .

Other chairwork techniques for re-evaluating the utility of coping modes include two-chair decisional balancing and the 'devil's advocate' technique (see Chapter 24).

Strengthening the healthy adult mode

The healthy adult mode plays a vital role in managing dysfunctional parent modes and caring for distressed child modes. This mode is usually under-developed at the outset of ST. Accordingly, therapists use chairwork to model the healthy adult, which is gradually internalised by the client (see the earlier three-chair dialogue with Kabir's punitive mode) (Young et al., 2003). Later dialogues focus on reinforcing clients' healthy adult mode. Relevant exercises include reparenting other individuals represented by an empty chair (Therapist: "Imagine your nephew were feeling a similar sadness

to your own; if he were sat in this seat, how would you soothe his pain?"); responding to one's child mode from the perspective of a 'healthy other' (see two-chair self-soothing; Chapter 19); and rehearsing healthy self-instruction in anticipation of distressing events (see 'emotion coaching' and 'behavioural instruction'; Chapters 19 and 20). Clients can also consolidate their healthy adult mode by sharing the therapist's perspective, as the following transcript illustrates.

Kabir: I tried to avoid alcohol at the party but I felt so anxious. I ended up getting really drunk. [*Becomes tearful*]. I'm such a failure.

(*Kabir's vulnerable child mode appears to be activated. The therapist now invites him to reflect on this setback from a healthier interpersonal perspective*).

Therapist: Do you think I think you're a failure?
Kabir: I know you don't see me that way.

(*Using the therapist's perspective as a reference, Kabir is prompted to expand on this healthy point-of-view*).

Therapist: If you were me right now, how would you see what happened?
Kabir: You'd probably say setbacks are normal.

(*Acting as a 'co-therapist' helps Kabir decentre from his vulnerable child mode and consolidate his healthy adult perspective*).

Therapist: Can you come over here and be my co-therapist? [*Kabir moves to a chair beside his therapist*].

Over in that chair is someone who's finding it difficult to stop using an old way of coping. [*Gestures to Kabir's former chair, representing the vulnerable child*]. As my co-therapist, would you say he's a failure for having that experience?

Kabir: I'd say it's good he's trying to change.

Therapist: What would you want him to know and understand?

Kabir: Changing old habits takes time.

(*Now Kabir is connected with his healthy adult mode, the therapist invites him to dialogue with his child mode*).

Therapist: That's right. Can you say that to your vulnerable side? [*Gestures to Kabir's former chair*]. I think Little Kabir could do with some encouragement right now. . . .

Dysfunctional modes are rarely eliminated altogether during ST; clients also need to learn how to defuse from these self-experiences. Another role of the healthy adult is to provide a decentred perspective on mode activation. Clients rehearse this transcendent point of view by standing and surveying how modes (represented by empty chairs) interact during chairwork. Therapists will usually stand with the client when doing so, forming a metacognitive 'healthy consultation team' (Roediger, Stevens, & Brockman, 2018).

Body-focused interventions for strengthening the healthy adult mode are sorely lacking in the ST literature. Schema therapists can learn much from CFT in this regard. Embodied approaches to cultivating the 'Compassionate Self' (which I would view as fairly synonymous with the healthy adult mode) through chairwork are presented in Chapter 25.

27

Using chairwork in positive CBT

Positive psychotherapy aims to promote growth, resilience, and well-being (Rashid & Seligman, 2018). Positive forms of CBT have emerged in recent years (e.g. Fava, Rafanelli, Tomba, Guidi, & Grandi, 2011). Seldom utilised, chairwork offers a powerful augmentation to these approaches.

Strengths

Strengths-based CBT (Padesky & Mooney, 2012) aims to identify the strengths and resources which enable individuals to pursue 'never miss' activities despite recurrent obstacles. Generalisable strategies which maintain resilience in the face of challenges are subsequently identified and applied to clients' difficulties. How chairwork might be applied in this approach is demonstrated in the following transcript.

Jane is identifying the strengths she uses when crocheting.

Therapist: So, two strengths help you with your crochet: patience and committing to finishing each piece.
Jane: Right.

(*Chairwork is now used to elaborate and concretise Jane's strengths*).

Therapist: Imagine this chair represents your patience. [*Introduces chair one*]. Can you switch seats so

we can get to know this strength better? [*Jane moves to the 'patience' seat*].

(*The therapist explores beliefs and strategies which maintain Jane's patience*).

Therapist: What attitude sustains your patience whilst crocheting?
Jane: I remember every design improves my ability. Remembering how good it'll feel when I finish the piece also helps!
Therapist: What if there's a setback in your design? How do you use patience then?
Jane: I just back-track and figure out what happened.
Therapist: Nice approach. Would you mind now standing behind the patience chair? [*Jane stands*].

(*Standing brings power and energy to Jane's embodiment of her strength. The therapist joins her in standing, forming a 'strengths-focused team'*).

Therapist: Patience is clearly a strength of yours, Jane. I wonder how it might also help in terms of addressing your eating disorder. What obstacles are likely to come up during that work?
Jane: The meal plan has been difficult. It's hard to keep eating when it makes me feel so full.

(*The therapist introduces a second chair to externalise this challenge*).

Therapist: Let's put 'feeling full' in a second chair. [*Introduces chair two, facing the 'patience' chair*]. Looking down on this challenge from the

	perspective of your strengths, how could patience help? [*Gestures to chair two*].
Jane:	[*Thinking*]. . . . I can remind myself that feeling full will get easier every time I eat. I just need to hang in there. If it feels really tough, I can step back and figure out why that is.
Therapist:	Sounds like a great strategy.

(*Now Jane has a sound strategy, the therapist introduces another strengths-focused perspective*).

Therapist:	What was the other strength we identified?
Jane:	Commitment.
Therapist:	That's right! Let's put 'commitment' in another seat and switch chairs again. How could this strength help with eating more and feeling full? . . .

Gratitude

Gratitude is associated with increased well-being (Dickens, 2017). Gratitude-focused interventions usually involve thinking or writing about one's gratitude (Toepfer, Cichy, & Peters, 2012). Empty chair dialogues provide a more evocative medium for expressing gratitude to others and, more importantly, witnessing their positive responses.

Kabir has written a letter of gratitude to his uncle.

Therapist:	How would you feel about bringing this letter to life?
Kabir:	Ok.

Therapist: I'd like you to picture your uncle in this seat. [*Introduces a chair*]. How does he look at you?
Kabir: He's smiling.
Therapist: How do you feel seeing him?
Kabir: I am always happy being around him.

(Kabir's reaction suggests he is in 'contact' with his uncle).

Therapist: Would you be willing to share your letter of gratitude with him? . . .

Kabir reads his letter aloud.

Therapist: . . . That was beautiful, Kabir.
Kabir: Thanks.

(*The therapist prompts Kabir to witness how his uncle responds to his gratitude*).

Therapist: How do you imagine your uncle reacts to hearing your letter? [*Gestures to the empty chair*].
Kabir: [*Laughs*]. He's chuckling. He's happy knowing I've valued his guidance.

(*Kabir's uncle is invited into the dialogue to deepen these positive emotions*).

Therapist: Having heard your letter, what do you imagine your uncle wants *you* to know? What does he say in response?
Kabir: He says that he loves me just as much. . . .

Forgiveness

Forgiving others is associated with a host of emotional benefits (Karremans, Van Lange, Ouwerkerk, & Kluwer, 2003). CBT has informed several effective interventions for facilitating forgiveness (see Wade et al., 2014). Chairwork can augment these treatments in the following ways:

- Clients often need to express anger at offenders prior to forgiving. Empty-chair techniques can be used to facilitate ventilation (Therapist: “Imagine the offender in this chair – tell them how their actions have hurt you”).
- Interviewing the ‘resentful’ part of the client through intrapersonal role-play clarifies the functions and concerns related to a refusal to forgive (see Chapter 21) (Therapist: “As the resentful side, how are you trying to help this individual? What are your concerns about allowing them to forgive?”).
- Ambivalence about granting forgiveness is resolved through two-chair decisional balancing (see Chapter 24).
- Objectivity regarding the offense is developed by asking clients to describe the transgression from three viewpoints: their own perspective (chair one), the offender’s perspective (chair two), and, finally, the perspective of a neutral witness (chair three).
- Speaking with the offender can generate empathy for their actions. This might take the form of empty chair dialogues or role-plays in which the client enacts the antagonist. Worthington (2006) recommends exploring five issues with offenders during empathy-focused dialogues: (1) situational pressures which may have led them to commit the offense; (2) past experiences which contributed to their behaviour; (3) aspects of their personality which played a role; (4) ways the victim may have provoked the offence; and, (5) whether their actions had any benign intent.

- Empty-chairwork or role-play (with the therapist enacting the offender) can provide clients with a proxy experience of apology and reconciliation.
- Future-orientated role-plays help prepare for interactions with the offender and discussions about the transgression.

Self-forgiveness

Individuals often experience distress as a result of perpetrating or failing to prevent acts which transgress personal values ('moral injuries'). Adaptive disclosure is a CBT-allied treatment which utilises imagery to encourage unburdening and self-forgiveness (Litz, Lebowitz, Gray, & Nash, 2016). These interventions lend themselves well to chairwork. Adaptive disclosure through chairwork can be facilitated as follows:

- *Stage one*: The client imagines the 'victim' of the transgression in the empty chair and begins the process of disclosure.

Therapist: Can you picture them [*the victim*] in the chair? Tell them about your relationship before the transgression. . . .

- *Stage two*: The client describes the transgression and the impact this has had on their life. Emphasis is placed on disclosing the burden the client has been left with.

Therapist: Tell them about what happened. What feelings has this event left you with? How has

> life changed for you? Can you share how troubled you feel because of what occurred? . . .

At this point, clients may wish to apologise for the offence.

> *Therapist:* Would you like to tell them how sorry you are and why? . . .

- *Stage three*: The therapist explores how the other responds to their disclosure. The therapist actively highlights forgiveness-related responses.

> *Therapist:* What do they say after hearing your disclosure? . . . It sounds like they know it wasn't your fault. They know everyone makes mistakes and forgive you. . . .

- *Stage four*: The dialogue ends with the client saying goodbye to the victim and letting go of the transgression.

> *Therapist:* What do they say to you to help you move on? How would you like to say goodbye to them and move on from what happened? . . .

An alternative approach involves the client disclosing the offence to a compassionate moral authority through chairwork. Beforehand,

therapists assess whether this authority holds the client's true interests at heart and seems unconditional in their positive regard. Possible moral authorities may include respected individuals or divine beings. The dialogue then proceeds as follows:

- *Stage one*: The client imagines the moral authority in the empty-chair.
- *Stage two*: The client tells the authority about the transgression, including what occurred, how they have been affected, and their remorse.
- *Stage three*: The client describes how the authority responds to their disclosure.

> *Therapist:* After listening to what occurred with a kind and open heart, what do they [*the moral authority*] say in response? What do they think about this transgression? What advice do they want to share with you? . . .

- *Stage four*: The therapist guides the dialogue toward forgiveness and compassion-related themes.

> *Therapist:* Ask whether they forgive you and why. . . . Ask whether they still love and accept you. . . . Ask whether they believe you should continue to suffer. . . . How do they show understanding for your actions in the context of your life experiences, human imperfection, and the difficulties of this situation? . . .

Resistance to self-forgiveness is not uncommon during adaptive disclosure. Accordingly, these dialogues often require repetition. If

the client refuses to forgive themselves, chairwork might move on to address potential obstacles such as self-criticism (Chapters 21, 25, and 26) and ambivalence about self-forgiveness (Chapter 24).

Hope

Hopes refers to the ability to conceptualise, pursue, and persevere in the fulfilment of meaningful goals (Snyder, 2002). Within the context of CBT, hope encourages behaviour change and persistence. Hope-focused interventions include techniques for 'hope finding' (identifying sources of hope) and 'hope reminding' (bolstering hopeful cognitions) (Lopez et al., 2004). Chairwork enhances hope finding by identifying and elaborating 'hope markers' which arise within the therapeutic dialogue.

Jane is feeling hopeless about recovering from her eating disorder.

Jane: Sometimes I doubt I'll ever recover.
Therapist: Yet you've chosen to be here today. Why?
Jane: [*Thinking*]. . . . I suppose some part of me thinks things could change.

(*Asking Jane to enact her 'hopeful side' in a different chair consolidates this perspective and extracts it from her narrative of hopelessness*).

Therapist: Let's get to know this hopeful part better. [*Introduces a chair*]. Can you take the seat of Jane's hopeful side? [*Jane switches chairs*].

(*Jane is invited to speak from a perspective of hopefulness*).

Therapist: What makes this part of you optimistic about change?
Jane: I guess my eating has improved a little over the last year. I think I can make more changes.

(*The therapist prompts Jane to expand upon her hopeful cognitions*).

Therapist: What makes you hopeful about Jane's ability to do that? [*Gestures to Jane's original chair*].
Jane: She's hardworking. When she commits to something, she follows through. . . .

Next, therapists elaborate hope-focused dialogues by practising hope-focused self-instruction (i.e. 'hope reminding').

Transcript continued. . . .

(*Chairwork is now used to rehearse hope-focused responses to Jane's NATs*).

Therapist: So when Jane doubts herself [*gestures to her original chair*], what can this hopeful side say to encourage her? Tell her.
Jane: [*To the empty seat*]. You can do this, Jane. Recovery is going to be worth it. . . .

Soliciting encouragement from supportive individuals, via role-play, can also consolidate hope-related appraisals (Therapist: "If your best friend were sat in this chair, what would they say to maintain your hope? Change seats and speak from their perspective").

Meaning

CBT has increasingly recognised the importance of transcendent issues such as purpose and existential meaning (Hofmann & Hayes, 2018; Wong, 1997). Indeed, higher-meaning has been centralised in approaches like ACT, and is believed to play an important role in pursuing values-driven behaviours and finding meaning in one's suffering. Clients can explore higher-meaning by role-playing versions of their self at different points in time (i.e. temporal perspective-taking). These might include their younger self (Therapist: "Be your self at age 18 in this chair – as this past self, what do you hope your life will stand for?") or a wise, future self (Therapist: "In this seat, be an older and wiser version of yourself – as you look back over your life, what have been the most meaningful aspects? What advice would you give your younger self?"). Speaking from the perspective of one's personal values also promotes committed action and meaningful decision-making (Therapist: "Speaking as your value of charity in this seat, which of these behaviours/choices/directions in life seems most advisable?").

28

Using emotion-focused chairwork to augment CBT

Avoidance of emotional processing plays an important role in the maintenance of depression and anxiety. Unfortunately, CBT lacks effective interventions for overcoming such obstacles. For this reason, CBT has sometimes been combined with emotion-focused chairwork techniques, which are designed to enhance emotional processing; an integration which has produced promising results (see Chapter 15). This chapter introduces two emotion-focused chairwork techniques which can help clients approach, process, and resolve distressing emotions most productively in CBT: ‘unfinished business’ and ‘self-interruption’.

A brief introduction to emotion-focused chairwork

Chairwork represents one of several ‘tasks’ which are used to transform distressing emotions in emotion-focused therapy (EFT). EFT is an evidence-based psychotherapy which is based on the theory that maladaptive (i.e. unhelpful) emotions can be reduced through the activation of adaptive (i.e. helpful) emotions. To illustrate, anxiety (a maladaptive emotion) stemming from social phobia can be transformed into self-compassion (an adaptive emotion) by helping the client connect with their sadness related to social isolation (Shahar, 2013). For detailed transcripts of emotion-focused chairwork, see works by Leslie Greenberg (Greenberg et al., 1993) and Robert Elliott (Elliott, Watson, Goldman, & Greenberg, 2004).

Interpersonal injuries ('unfinished business')

CBT lacks meaningful techniques for processing 'lingering feelings' towards other individuals. 'Unfinished business' is an iconic chair-based technique which aims to resolve interpersonal distress (e.g. feelings of grief or betrayal by others) or attachment-related injuries (e.g. parental criticism in childhood).[1]

Unfinished business takes place in five stages:

- *Stage one*: The therapist provides a formulation of the distressing interpersonal experience and invites the client to describe relevant episodic memories.

> *Therapist:* I sense a lot anger towards your father. Can you tell me about some of the times he hurt you as a child? . . .

- *Stage two*: Chairwork begins with the 'other' being placed in the empty chair. The client then expresses their immediate emotional reactions to this presence (e.g. sadness and anger).

> *Therapist:* Imagine your father in this chair. What happens when you see him? Tell him what you feel right now. . . .

- *Stage three*: The client expresses what was needed from the other or what they wish they had received.

> *Therapist:* Tell your father what growing up with him was like for you. What did you need from him as a child? . . .

- *Stage four*: The client changes seats and responds from the perspective of the other.

> *Therapist:* [*Client switches into her father's chair*]. You've heard what your daughter has to say about the pain she experienced growing up with you. As her father, how do you respond to that? . . .

Ideally, the client will now experience the other responding with compassion and apology. However, some clients may imagine the other responding with disinterest or criticism.

- *Stage five*: The client changes seats once more and responds to what the other has said. If the other has responded with compassion, the client's view of this individual will usually transform into one which is less distressing, separate from the self, and possessing both good and bad qualities.

> *Therapist:* [*Client remains in her father's chair*]. Explain to your daughter why you behaved the way you did. Are you sorry for how this has affected her? . . . [*Client returns to their chair*]. How do you feel hearing your father's apology? . . .

If the other has responded with criticism or disinterest in stage four, the client is supported in holding this individual accountable for their behaviour and/or lack of nurturance using adaptive anger.

> *Therapist:* [*Client returns to their own chair*]. Tell your father why it was wrong for him to behave the way he did. Share your anger with him. . . .

Whilst self-blame for the actions of the other individual may diminish at this point, disinterested responses usually stimulate considerable grief in the client too. Chair-techniques for eliciting self-compassion and self-soothing can be helpful at this point (see Chapter 19).

Emotional inhibition ('self-interruptive splits')

Emotional inhibition tends to arise when clients negatively appraise their emotions (e.g. "sadness is a sign of weakness") or believe expressing affect will have catastrophic consequences (e.g. "I will lose control if I get angry"). Unfortunately, CBT has few techniques for helping emotionally avoidant clients connect with their feelings. Given that many cognitive-behavioural techniques rely on a degree emotional arousal, this can be problematic.

Emotion-focused chairwork for emotional inhibition (or 'self-interruptive splits') is a powerful intervention involves a dialogue between the 'emotional part' of the client and the 'interrupting part' which blocks these feelings. CBT therapists might use this technique if a client appears emotionally detached or if affect abruptly disappears during the session. As with other emotion-focused techniques, emphasis is placed on encouraging the client to express their adaptive emotional reactions in response to having their feelings blocked. This contrasts with ST, wherein therapists will negotiate with the parts of the client underlying emotional inhibition (see dialogues with the 'detached protector'; Chapter 26).

Addressing self-interruptive splits takes place in five stages:

- *Stage one*: The client changes seats and enacts the self-part which inhibits their emotions. Emphasis is placed on describing the act of self-interruption.

Therapist: Change seats and be the side that pushes away your sadness. [*Client changes seats*]. Show me how this part smothers the pain. What does it say to force it away? . . .

- *Stage two*: The client returns to their chair and explores how it feels to be interrupted in this manner.

Therapist: [*Client returns to their chair*]. What's it like when your pain gets blocked like that? . . .

- *Stage three*: The client changes seats again and amplifies the act of self-interruption. This may include specifying the (imagined) dangers of emotional expression or physicalising the interruptive process (e.g. squeezing a pillow). Exaggerating self-interruption helps override what is often an automatic process, thus stimulating emotional expression (Greenberg et al., 1993).

Therapist: [*Client returns to the 'interrupting' chair*]. Make her numb again. Tell her why she mustn't feel. Hold back her tears. . . .

- *Stage four*: The client returns to their original chair and expresses their reactions to more intense emotional interruption. Therapists follow this by encouraging the client to articulate their needs regarding emotional expression.

> *Therapist:* [*Client returns to their chair*]. What happens to the pain when it gets flattened like that? What do you need from the side that squashes these emotions? Tell it why these feelings are important. . . .

- *Stage five*: Assuming this enactment has helped the client connect with their emotions, chairwork concludes with expressing the blocked feeling to either the therapist or another individual.

> *Therapist:* Imagine your boyfriend in this empty chair. Tell him about the sadness which you couldn't express up until now. . . .

Note

1. Emotion-focused chairwork techniques for resolving complex interpersonal traumas are described in other EFT literature (e.g. Paivio et al., 2010).

29

Using chairwork in CBT supervision

Effective cognitive-behavioural supervision is both a 'talking' and 'doing' process. Experiential methods are recommended across supervisory texts in CBT (e.g. Padesky, 1996, Milne, 2009) and allied approaches (e.g. Greenwald & Young, 1998). These methods are also evidence-based: role-play, for example, has been shown to enhance therapist competency, skill retention, and fidelity (e.g. Beidas & Kendall, 2010; Milne & Reiser, 2017). Unfortunately, experiential methods are used infrequently in CBT supervision (Townend, Iannetta, & Freeston, 2002) and many supervisors doubt their ability to apply these methods effectively (Owen-Pugh & Symons, 2013). Drawing upon the declarative-procedural-reflective (DPR) model of skill development (Bennett-Levy, 2006), this chapter describes how chairwork can augment supervision.

Technical competence

Assessing technical competence

Technical competence is assessed by inviting supervisees to demonstrate, through role-play, how core cognitive-behavioural interventions are implemented (Supervisor: "Show me how you introduce the cognitive-behavioural model – you play the therapist, I'll play the client"). Areas for technical development are subsequently identified (Padesky, 1996).

Building technical competence

The principles of behaviour skills training (see Chapter 20) provide a framework for developing technical competence (Table 29.1). In

Table 29.1 Steps in technical skills training ('I-MARCHED')

1. *Instruction*: The supervisor describes why and how the intervention is applied.
2. *Modelling*: The supervisor demonstrates implementing the intervention (ideally with the supervisee enacting the client). Supervisors might 'think aloud' during these demonstrations to highlight its key procedural steps (Safran & Muran, 2001).
3. *Assess learning*: Specific elements of the intervention are discussed in detail after role-play (e.g. process, content, etc.).
4. *Rehearsal*: The supervisee practises implementing the intervention (with the supervisor role-playing the client).
5. *Coaching*: Rehearsals are paused to provide supervisees with 'live' guidance and instruction when needed.
6. *Helpful feedback*: Praise and constructive feedback is provided after role-play. Adjustments in implementation are modelled by the supervisor.
7. *Edited rehearsal*: Role-plays incorporating the supervisor's feedback are initiated.
8. *Deepen learning*: Reflective questioning is used to consolidate learning after role-play (e.g. exploring implications for clinical practice; establishing links with conceptual knowledge; etc.).

summary, technical skills training involves the supervisor modelling a novel intervention, followed by supervisee rehearsals. To ensure these enactments are meaningful, supervisees are encouraged to bring their own clinical scenarios to role-play (Taylor, Russ-Eft, & Chan, 2005).

Fine-tuning technical competence

More challenging role-plays are utilised later in supervision to refine technical skills and practice working in pressured conditions (Supervisor: "This time I'm going to enact a withdrawn client – try and get me involved in agenda-setting").

Maintaining competence and fidelity

Intermittent role-plays allow supervisees to rehearse specialised interventions (e.g. imagery rescripting) and prevent technical decay.

In addition, regular role-plays bolster treatment fidelity by reinforcing key therapeutic procedures (Beidas & Kendall, 2010).

Perceptual competence

Empathic attunement

CBT therapists combine hypothesis-testing with an ongoing awareness of clients' moment-by-moment experiencing (Bennett-Levy, 2006). Empathic attunement is a complex perceptual skill which allows therapists to operate within the client's frame of reference. Adopting the client's perspective through role-play is an effective means to enhance empathy and attunement to client communications (Beck, Rush, Shaw, & Emery, 1979).

Jim, a supervisee, is discussing difficulties around setting agendas with a client.

Supervisor:	I wonder if recreating what happened when you set an agenda with Daniel could help us understand his experience.
Supervisee:	Sure.
Supervisor:	Let's move to different chairs and recreate that part of the session. I'll be the therapist and repeat what you said to Daniel. You respond as he did. [*Both switch seats*]. Ready?
Supervisee:	Ready.
Supervisor:	[*Enacting the supervisee*]. Ok, Daniel, what shall we put on today's agenda?
Supervisee:	[*Enacting the client*]. I'm not sure. What do you think?
Supervisor:	Do you remember why we set agendas in CBT?
Supervisee:	So that we cover everything we need to.

Supervisor: Correct. So, what shall we discuss?
Supervisee: [*Silent*]. I don't know.

(*The supervisor is interested in knowing whether speaking from the client's perspective has generated new insights for the supervisee*).

Supervisor: [*Leans forwards*]. Let's pause. What's happening for you right now?
Supervisee: I feel strangely nervous!
Supervisor: That's interesting.

(*Drawing upon the supervisee's experiential insights, guided discovery is used to develop a new understanding of the client*).

Supervisor: Perhaps your reaction says something about Daniel's experience. What might he be feeling anxious about?
Supervisee: Perhaps he's worried about getting the agenda wrong. . . .

Once better attuned to the clients' experiencing, roles are reversed so that supervisees are able to practice communicating their new empathic understanding.

Previous transcript continued. . . .

Supervisor: Let's role-play again, but this time you play the therapist. Try communicating your understanding about Daniel's anxiety.
Supervisee: [*Enacting the therapist*]. What shall we put on today's agenda, Daniel?
Supervisor: [*As Daniel*]. I'm not sure.

Supervisee: That's ok. I wonder if you might be feeling a little nervous about setting an agenda? [*Supervisor nods*]. Perhaps you're worried about getting it wrong? . . .

The supervisee goes on to use role-play to rehearse empathic communication.

Mindfulness

Mindfulness involves concurrent attendance to both the client's and one's own internal state during the therapeutic encounter (Bennett-Levy, 2006). Awareness-orientated role-plays (Safran, Muran, Stevens, & Rothman, 2007) are used to rehearse mindful attending and move supervisees from 'reflection on action' (i.e. post-event reflection) and towards decentred 'reflection in action' (i.e. reflection during the flow of therapy). In this type of role-play, the supervisee switches between chairs, speaking as both the therapist and the client, during key therapeutic junctures. Enactment is paused intermittently to guide the supervisee's attention inwards and generate meta-(observational) awareness of the unfolding interaction (Supervisor: "What thoughts and feelings are arising in response to what this client just said?" [*Gesture's to the client's seat*]).

Relational competence

Empathic communication

Whilst perceptual competencies focus on the client's experiencing (client-related 'inputs'), relational competencies relate to the therapists' subsequent responses (therapist-related 'outputs') (Bennett-Levy, 2006). Empathic communication is crucial to relational competence. As with technical skills, role-play allows supervisees to observe, rehearse, and fine-tune empathic communication. Contrasted role-plays

are a particularly helpful way for supervisees to 'discover' new, empathic ways of navigating difficult conversations.

> Jim was concerned that discussing missed appointments with his client might come across as confrontational. Contrasted role-plays were used to address this concern. Jim first role-played raising this issue with the client (played by his supervisor) in a forceful manner (chair one). Next, Jim role-played raising this issue in the most empathic manner possible (chair two). Finally, Jim practised speaking to his client in a manner balancing firmness and empathy (chair three). He agreed this final approach seemed most effective and non-combative.

Therapeutic ruptures

Ruptures in the therapeutic alliance often stem from interpersonal skill difficulties, which supervisees may be unaware of. Bennett-Levy, Thwaites, Chaddock, and Davis (2009) have outlined a staged approach to exploring ruptures which incorporates chairwork.

- *Stage one*: The rupture is recreated under the supervisee's direction.

> *Supervisor:* Let's change seats and recreate what happened in this session. You play the therapist, I'll play your client. . . .

- *Stage two*: Cognitions and emotions which arise for the supervisee during re-enactment are explored (i.e. experiential processing).

> *Supervisor:* What happened for you when we recreated this interaction? . . .

- *Stage three*: The supervisor and supervisee decentre from role-play by standing. A new conceptualisation of the event is then developed using the supervisee's experiential insights (i.e. reflective processing).

> *Supervisor:* Let's stand and look at this interaction from above. . . . How can we make sense of what's happening here? . . .

- *Stage four*: Reflective discussion is used to develop a new, conceptualisation-driven intervention. These are 'road-tested' through further role-play.

> *Supervisor:* Given our new understanding of this event, let's role-play a different way of responding if this issue were to arise again. . . .

Reflective competence

Resolving impasses

Reflection drives continued learning and the development of clinical expertise (Bennett-Levy, 2006). The need for reflective processing is often signalled when impasses arise in CBT. As with alliance ruptures, recreating impasses in supervision aids conceptualisation and can highlight subtle client communications which point towards solutions. Supervisors might also follow these re-enactments by demonstrating how they would respond in similar situations.

Inviting the supervisee to speak from the perspective of the obstruction ('impasse embodiment') also provides a novel method for exploring impasses.

> Jim's client talked in excessive detail. During supervision, Jim was asked to change seats and speak reflectively from the perspective of this client's 'rambling side'. Exploratory questions were then put to this part of the client (Supervisor: "When do you show up in therapy? What do you achieve by doing this? What might happen if you didn't perform this role? What do you need to show up less in therapy?"). Reflecting on this dialogue, Jim hypothesised that 'rambling' might help his client avoid emotive issues in therapy.

Egocentric-allocentric role-play also aids reflective processing by exploring impasses from multiple perspectives: the supervisee first describes the impasse from a self-immersed perspective (chair one) (Supervisor: "What challenges are arising in your work with this client and why they might be occurring?"), then from the client's perspective (chair two) (Supervisor: "What challenges do you experience in your work with this therapist and why might they be occurring?"), and finally from a standing, decentred perspective (Supervisor: "Observing this interaction, what do you notice happening between these individuals and why might that be occurring?").

Self-competence

Self-schemas and therapy-interfering beliefs

Self-competence relates to therapists' ability to recognise and manage aspects of the self which impact upon therapy. Clinician anxiety and self-schemas can diminish confidence and motivate avoidance, for example. Role-playing interactions which activate self-schemas helps desensitise supervisees to these events and build confidence. Therapy-interfering beliefs on behalf of the supervisee may also obstruct CBT (e.g. "agenda-setting stifles the client"). Role-reversal is called for here: supervisees enact the client during role-play to 'test out' whether these beliefs hold true from an external perspective (Padesky, 1996).

> Jim believed that requesting feedback from his clients would be experienced as artificial. To test this belief, Jim role-played a client whilst his supervisor modelled asking for feedback. He subsequently concluded that soliciting feedback could be a positive experience for clients. However, he was concerned that doing so may elicit criticism. To build his confidence, Jim practised responding to negative feedback in follow-up role-plays with his supervisor.

Difficult feelings towards the client

Self-competence also requires an ability to 'work through' problematic thoughts and feelings towards the client (i.e. 'counter-transference'). Chairwork provides a medium for resolving these responses. 'Self-doubling' is an evocative technique which aims to ameliorate problematic therapist reactions and build empathy for 'difficult' clients (Kellogg, 2015). This exercise can be summarised as follows:

- *Stage one*: The supervisee conveys to the client (represented by an empty chair) how they experience the therapeutic process.

> *Supervisor:* Imagine your challenging client were sat in this empty chair. Tell them, openly and honestly, how you feel about your work together. . . .

- *Stage two*: After reflecting on this disclosure, the supervisee embodies the client and describes their authentic experience of therapy.

> *Supervisor:* Change seats and step into the shoes of your client. [*Supervisee switches chairs*]. Speaking as this individual, what is life like for

> you? What is your true experience of therapy and working with this therapist? If they could know and understand one truth about you, what would it be? . . .

- *Stage three*: The supervisee returns to their original chair and articulates subsequent changes in how they perceive and understand the client.

> *Supervisor:* Come back to your original chair. [*Supervisee switches again*]. How does this client appear to you now? Knowing their true experience, tell them what you understand and how your work will proceed differently. . . .

Troubling reactions towards clients can also be explored through the lens of supervisees' 'emotional selves' (see Chapters 19 and 25). This exercise invites the supervisee to explore their experience of the client from the embodied perspective of their 'Angry Self', 'Sad Self', and 'Anxious Self'. Memories associated with each self will often point towards key therapist schemas underlying problematic reactions. As with CFT, this dialogue concludes with the supervisee switching seats and speaking from the perspective of their Compassionate Self or 'Compassionate Internal Supervisor'. Care, validation, and advice is provided to each emotional self from this perspective and, if appropriate, the client as well (Supervisor: "From the perspective of your Compassionate Self, how do you now view this client and their suffering? [*Gestures to the empty chair representing the client*]. Is there anything you want them to understand?"). Similar dialogues are utilised in schema therapy supervision: the supervisee describes problematic reactions to the client from the perspective of relevant schema modes, which are then contained by the healthy adult mode (also enacted by the supervisee or, if necessary, the supervisor).

30

Addressing common obstacles when using chairwork

Chairwork raises unique challenges in CBT. This final chapter presents common obstacles when applying these techniques and proposes solutions.

Extra chairs are unavailable

Whilst chairs are always preferable, clients can speak from other spatial locations. These might include standing behind or in front of their chair; from the therapist's chair; or to the left or right of these seats.

The client doesn't think chairwork will be helpful

Therapists frame chairwork as an experiment worth trying. Therapists also preface chairwork with a rationale prior to use (see Chapter 16). If the client feels self-conscious, therapists initially model the dialogical process by enacting self-parts under their direction. Dialogues with the client's 'sceptical' or 'avoidant side' might also be productive.

The client feels anxious about the emotional intensity of chairwork

Clients are reassured that they retain control over the dialogical process. Strategies for managing intense emotions are discussed before chairwork (e.g. incorporating a 'safe chair' into the dialogue or

agreeing signals the client will use if they feel overwhelmed). Therapists check in with the client throughout the enactment to ensure their emotions remain tolerable.

The client struggles with emotional regulation

Chairwork can be approached in a step-wise manner with emotionally under-regulated clients. Initially, self-parts are simply named and placed in chairs. Next, therapists model interactions between self-parts under the client's guidance. Figurines can also be used to represent self-parts (Arntz & Jacob, 2013). Finally, clients voice self-parts from a distanced, third-person perspective (Therapist: "What is the critical side saying to the criticised side [*gestures to chairs one and two*]?"), before moving onto more emotive first- and second-person dialogues.

The client feels unsafe dialoguing with distressing self-parts or abusive individuals

Ways to make chairwork feel safer are agreed. These include inviting the client to standing behind their seat during dialogues; building a protective 'wall' of chairs between the client and the opposite chair; or the therapist speaking on the client's behalf (Kellogg, 2017).

The client finds it difficult to visualise the 'other' in the empty chair

Surrogate items such as photographs, figurines, drawings, and symbolic items can be used to concretise self-parts or other individuals.

The client becomes highly distressed during chairwork

Therapists aim to raise affect to a level which is high but tolerable during chairwork. However, they must also ensure clients are not overwhelmed. If the client becomes highly aroused, therapists slow the dialogue and prioritise containment before pressing ahead.

The client remains emotionally detached during chairwork

Clients' reasons for remaining detached are explored and validated after chairwork. Follow-up dialogues with the self-parts which inhibit emotions may be helpful (see Chapters 26 and 28). Therapists might also model emotional expression in order to encourage the client.

The client feels guilty when confronting certain individuals (e.g. a parental figure)

Two chairs can be used to represent polarised experiences of others (Kellogg, 2017). For example, chair one might hold positive aspects of a caregiver which are acknowledged ('my mother when she was kind'), whilst chair two holds negative experiences of a parent which are confronted ('my mother when she was cruel') (Kellogg, 2017).

Dialogues between self-parts reach 'stalemate'

Stagnant dialogues are enlivened by incorporating another perspective into chairwork (Rowan, 2010). For example, if the client remains undecided after two-chair decisional balancing, a third chair representing their personal values might be introduced.

The client submits to distressing self-parts or individuals ('collapse' or 'defeat')

These reactions are not uncommon when dialoguing with the 'inner critic' or abusive caregivers. Given that agreement with maladaptive self-parts is often a cognitive event (Client: "I believe there is truth in what my inner critic is saying. . . ."), therapists respond by directing clients' attention to their affective responses (Therapist: ". . . But how does that part make you *feel*? What does that sadness tell you?"). Alternatively, therapists can shift the client into more productive modes of processing by asking them to embody other (functional) self-parts (Therapist: "Switch seats and respond to those criticisms from your compassionate side; the part which sees things differently; as if your critic were attacking someone you care about").

The client is unable defend themselves during a dialogue

Assuming it is compatible with the model of therapy being used, this response may justify therapist intervention (Therapist: "Would it be ok if I said something to that critical side?").

Chairwork fails to produce a positive outcome

Client feedback sometimes highlights ways in which the dialogue could have proceeded more productively. Dialogues incorporating these suggestions might then be enacted. Therapists should also hold in mind that some dialogues require repetition to achieve full effects (e.g. chairwork with core beliefs, self-criticism, and abusive caregivers).

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