DIALOGICAL ENCOUNTERS: CONTEMPORARY PERSPECTIVES ON “CHAIRWORK” IN PSYCHOTHERAPY

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This article looks at the use of “chairwork” (2-chair and “empty” chair) dialogues through the lens of 5 psychotherapies: Gestalt, process-experiential therapy, reddecision therapy, cognitive–behavioral therapy, and schema therapy. Many clinical examples are provided, and they are organized into 4 overlapping groups: (a) internal in focus; (b) external in focus; (c) conflictual, that is, whether they involve the replaying of difficult or traumatic scenes from the past; or (d) corrective, which means that the emphasis is on replacing maladaptive cognitions or schemas with ones that are healthier. A potential foundation for Gestalt and cognitive–behavioral integration is proposed on the basis of the idea that gestalts are schemas (I. G. Fodor, 1996) and that chairwork is actually a form of cognitive restructuring (D. J. A. Edwards, 1989).

The use of chairs in therapeutic dialogue, or “chairwork,” is a powerful, effective, and creative intervention for psychological change and transformation. The purpose of this article is to outline contemporary visions of how chair dialogues can be used as seen through the lenses of several psychotherapeutic schools. The patterns and structures that emerge from this exploration can help guide therapists in their use of this approach while laying the foundation for future developments.

Chairwork, which originally developed as a technique used in psychodrama (Carstenson, 1955; Fowler, 1992; Lippitt, 1958; Perls, 1973), is probably most readily associated with Fritz Perls (1973, 1975) and Gestalt therapy, with Esalen and the “hot seat” (Perls, 1969a, 1969b). If chairwork is seen as being only in the province of the Gestalt therapists, then the future of this intervention may be somewhat restricted. While Gestalt therapy has spread throughout the planet with Gestalt institutes in major cities (Greenberg & Brownell, 1997), a recent Delphi study on the future of psychotherapy (Norcross, Hedges, & Prochaska, 2003) found that experts in the field believed that the influence of Gestalt therapy would continue to decline over the next 10 years. In comments that were germane to this article, the panel of experts believed that cognitive–behavioral and integrative therapies would continue to grow in prominence and importance, and they also noted that the newer therapies tended to incorporate valuable aspects of earlier therapeutic schools—meaning that vitally important ideas were not being lost to the field.

The Five Psychotherapies

This article primarily looks at chairwork through the lens of five psychotherapies: Gestalt therapy (Baumgardner, 1975; Perls, 1969a, 1973, 1975); process-experiential therapy (Elliot, Davis, & Slatinick, 1998; Greenberg, 1979; Greenberg, Rice, & Elliot, 1993; Greenberg, Watson, & Goldman, 1998; Wolfe & Sigl, 1998), which is a combination of Gestalt, experiential, and client-centered therapies; reddecision therapy (Goulding, 1972; Goulding & Goulding, 1997; Lennox,
Therapeutic Paradigms

Each of the therapies has shared and unique visions of the therapeutic process, the desired goal or outcome, and the role of the therapist. These differences can be clearly seen in the ways that chairwork is undertaken and understood. In a chapter with great relevance to this article, Greenberg, Safran, and Rice (1989) explored the differences between experiential and cognitive–behavioral therapies. They described the experiential therapies as facilitating; the goal was to help the patient grow in awareness so that whatever was unresolved, whatever was necessary for healing and transformation, would emerge from within. The cognitive–behavioral therapies were described as modifying; here, the therapist is actively seeking to make changes in the patient’s inner world.

An examination of the five therapies reveals a further delineation of the modifying group. While the Gestalt and process-experiential therapies are facilitating, among the modifying approaches, redecision therapy is a conflict therapy, Goldfried’s (1988) rational restructuring approach is a corrective therapy, and schema therapy is both a conflict and a corrective therapy. The conflict therapies, typically through the use of chairs and imagery, bring the patient back to a dysfunctional or traumatic scene or series of scenes from childhood. In redecision therapy (Goulding & Goulding, 1997), it is believed that the child is receiving a poisonous message from a parent or another powerful figure, a message that is called an injunction. This is conveyed through the words and actions of this figure. The child, as a means of survival, makes a decision to accept the pathological injunction. This sets into play a dysfunctional script or a lifelong pattern of problematic behavior. Using chairs and imagery, the patient is brought back to a scene that connects to the original injunction and acceptance decision. The patient now confronts the parent or pathogenic figure or figures and tells them that he or she will no longer accept the injunction and the patient will now live his or her own life, in defiance of the figure, if necessary.

In schema therapy (Young et al., 2003), the patient is also thought to have been through a series of traumatic or pathogenic situations. These experiences can lead to the development of early maladaptive schemas. Schemas are thematic structures “comprised of memories, emotions, cognitions, and bodily sensations” (Young et al., 2003, p. 7) that serve as a blueprint for the child’s world. Again, while they may have had a survival value for the child in a dysfunctional situation, they typically impair later functioning. They are also seen as being a core component of the Axis II disorders as well as many Axis I disorders—especially those that are recurring. Patients often experience schemas as upsetting memories. Chairwork and imagery are used as ways to rework them. When the patient and therapist replay these scenes, the therapist will often confront abusers first while nurturing the image of the patient as a small child. The therapist will also help the patient confront abusers in the “empty” chair. It is this active and directed attack on people who had wronged patients that allows these two approaches to be labeled as “conflict therapies.”

Goldfried (1988, 2003; Samoilov & Goldfried, 2000) has written on the use of chairs in his rational restructuring/cognitive–affective therapy. Like other cognitive therapists, he is trying to replace dysfunctional thinking with more adaptive thinking. He advocates the use of chairs because he is aware that cognitive shifts are more likely to take place if there are higher levels of affect, and he believes that the use of chairs engenders greater levels of emotion arousal. In his model, one chair represents the dysfunctional thinking pattern, while the other represents the healthier alternative—an alternative that may be jointly created by the therapist and the patient. Schema therapy also uses chairs to dispute the validity of the schemas, and, in this regard, it is also a corrective therapy.

What these therapies share in common is the belief that events from the past continue to play a
Tobin (1976) wrote the following:

For example, one man as a child was continually humiliated and rendered helpless by his father. To express his rage toward his father would have meant his own destruction. Today he continually attempts to finish this situation by provoking authority figures into attacking him and then attacking back. (p. 374)

**Therapist Roles**

The differences between the facilitating approach, on the one hand, and the modifying approaches, on the other hand, can be clearly conveyed in the dramatically different perspective on the therapist's role. Greenwald (1976), writing from a Gestalt perspective, described the psychotherapist's work in this way:

The therapist rejects any kind of authority position toward the person with whom he is working. The therapist does not attempt to lead, guide, advise, or in other ways take away the other person’s responsibility for himself [or herself]. Rather, his attitude is that each person knows best what he needs for himself and how to get it; even when he is stuck, he is more capable of finding his solutions than anyone else. (p. 278)

This view stands in stark contrast to that of Goulding and Goulding (1997), who see the therapist in a much more active role:

In redecision therapy, the client is the star and the drama is carefully plotted to end victoriously... The therapist is the director of the drama, writer of some of the lines, and occasionally interpreter... We do not want to produce tragedies—we are interested in happy endings. (p. 177–178)

In an earlier passage, Goulding and Goulding (1997) clearly delineated the goal of the therapy when they said, “We are focused exclusively on what the client needs in order to renounce victimhood” (p. 168).1

**Dimensions of Dialogue**

Analyses of case scenarios support the use of several dimensions in attempting to understand chairwork. There are three overarching dimensions that emerge in the use of chairs—external, internal, and corrective—and each of these has a number of subthemes.

**External Dialogues**

External dialogues frequently consist of what Greenberg (Greenberg et al., 1993; Paivo & Greenberg, 1995) has referred to as “unfinished business.” This typically occurs when an individual feels that events that took place in the past with significant others or important people in their lives are not resolved (see also R. Elliott et al., 1998).

Goulding and Goulding (1997) described many cases that fit this pattern. As noted above, their patients have typically gone through a series of traumatic experiences with a family member or another significant individual. This led them to make a decision that served as the nucleus of an ongoing pattern of troubled or diminished functioning. In therapy, the patient imagines a scene from his or her past that relates to the difficulties that he or she has been having, and this serves as the basis of the work. The dialogue with the person in the empty chair is confrontational, and the goal is for the patient to repudiate the original maladaptive decision and announce his or her voluntary adoption of a new decision, a healthier perspective on life.

A patient with workaholic tendencies remembered a situation in which, as a child, he asked his father if he could sign up for a Little League team; his father told him that he could not because he had to help him work on the farm instead. In the chairwork encounter, he again asked his father if he could join the team, and when his father told him that he could not, he defied his father and said that he would do it anyway. He also put his father in the chair, and, in a two-chair dialogue, asked his father why he was that way. After his “father” spoke of the poverty and desperation that he had been faced with, the patient affirmed that while that may have been true for his father, it was no longer true for himself. He then went on to restructure his life in such a way that he had more time for play and self-development instead of constantly working (Goulding & Goulding, 1997).

In these dialogues, sometimes the parent figure will change and support the patients’ new decision and sometimes they will not. If not, Goulding and Goulding (1997) encourage the patient to

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1In my opinion, Perls, in the transcripts of his work at the end of his career (Perls, 1969a, 1973, 1975), appears to have been more of a modifying than a facilitating therapist. I feel that he worked with a therapeutic agenda that was often focused on polarities and centeredness. This therapeutic “activism” may have put him at odds with other members of the Gestalt community (i.e., From, 1984), who could more clearly be defined as taking a facilitating approach.
make the decision in defiance of the parent. They then ask the patient to find other supportive figures (such as other family members or teachers) who will support the patient in the change process. These individuals are then put in the chair, and they express their support for what the patient is doing. Another variant is to have patients become a new, affirming father or mother to themselves. This new “parent” takes a chair and talks to him- or herself as the child in the original scene, supporting the child in changing his or her life (Goulding & Goulding, 1997). As Mary Goulding (Goulding & Goulding, 1997) told a patient named Abe, “Tell you what, make up a new father. . . . Be the kind of father you want now. . . . and tell Abe what you enjoy about him” (p. 77). In this way, she was trying to create more positive introjects. In the language of transactional analysis, she was strengthening the nurturing parent at the expense of the critical parent; in schema therapy language (Young et al., 2003), she was developing the healthy parent and diminishing the power of the punitive parent.

Not infrequently, these scenarios involve traumatic or humiliating situations. In situations in which men are reworking experiences of having been bullied, more than one empty chair can be used so that each persecutor can be addressed personally. Using a schema therapy approach, this may be combined with imagery techniques in which patients can relive an earlier scenario; this time, however, they are given a weapon so that they can defend themselves directly or, if that feels too difficult, their adult selves or the therapist steps in and defends the child self.

As noted above, Goulding and Goulding (1997) have some clear goals behind their interventions. They want to “turn the scene from [a] tragedy to a drama that ends well” (p. 168). It is interesting to note that they emphasize the crucial importance of the patient making a decision to change. They feel that patients who are prone to blaming others actually want the other person to change their behavior; this, however, will not be therapeutic.

This belief underlies Goulding and Goulding’s (1997) work with people who have suffered from sexual and physical abuse. The structure that they use takes this form:

1. The patient describes an abuse scene from the perspective of an outside observer.

2. The patient and the therapist then discuss the scene to clarify the details.

3. An empty chair is then brought in for the abused “child,” and the patient and abused child have a two-chair dialogue about the experience.

4. The next step is to have the child relive the traumatic scene; the child tells the story as he or she experienced it. As in schema therapy, if this is too overwhelming, the patient may bring in a protective figure as support (the therapist, an adult version of one’s self, an armed protector), and he or she is also allowed to leave the scene at any time.

5. The abuser is then put in the empty chair and is confronted. In this scenario, the perpetrator is not allowed to change. He or she is not allowed to apologize or promise to behave differently. Again, this is because the goal is to have the patient change. The patient then clearly says how he or she will live life, a life that will be created in defiance of what the abuser did.

Examples of rededications include (a) “From now on, I am going to find trustworthy people, and I will trust them. Everyone is not like you.”; (b) “I enjoy sex today in spite of what you did to me. You are no longer in my bed.”; and (c) “I can laugh and jump and dance without guilt, because my fun didn’t cause you to rape me! It was your perversity!” (Goulding & Goulding, 1997, p. 248).

Not surprisingly, these scenes may need to be revisited a number of times before this kind of resolution can take place. Goulding and Goulding (1997) emphasized that no matter what happened or what the children did, all guilt lies with the perpetrator. If the patient has difficulty with feelings of guilt, the therapist will organize a two-chair dialogue with one chair centered on “I am guilty” and the other chair centered on “I am not guilty.” The ensuing dialogue will help resolve this issue.

In the case of emotional abuse, patients fight back in the scenes and repudiate the toxic messages that are being given to them. They are encouraged to be self-affirming. Unlike in cases of physical and sexual abuse, sometimes the figures are put in the chair so that the patient can better understand what drove them to behave that way.
and how they may have been projecting their own issues onto the patient.

Using combinations of imagery and chairwork, Young et al. (2003) also has patients challenge parental figures, other figures from their past, and people in their current life situation. This is done to help break the strength of the schema, which bears some similarity to the injunction–decision dynamic.

**Saying Goodbye**

A specific form of unfinished business is “saying goodbye.” In this situation, the patient is holding onto a relationship that has ended or no longer exists. This connection serves to stifle the patient’s growth and prevent further development. “The individual is still carrying around much unexpressed emotion: old resentments, frustrations, hurts, guilts, and even unexpressed love and appreciation” (Tobin, 1976, p. 375). Not only may people need to say goodbye to those who have died or those whose relationships have ended through such events as divorce or matura-
tion, they may also need to release their connection to people who they do not know, such as fantasy figures, geographical locations, careers, personal dreams, and body parts if these investments are tying them to the past (Goulding & Goulding, 1997).

In a Gestalt approach (Tobin, 1976), patients are asked if they want to say goodbye to some-
one. Patients are then asked to invite the individual into the empty chair. They are asked what they are experiencing as they imagine that person, and they are then encouraged to express those feelings to them. Patients then switch chairs and respond from the perspective of the deceased or missing person. Keeping with the Gestalt emphasis on balance, it is of great importance that patients ultimately express both the resentments and the appreciations that they have for this person (Perls, 1975). “In almost every case there is much emotion expressed—anger, hurt, resentment, love, etc.” (Tobin, 1976, p. 379). After this dialogue has been concluded, the therapist asks patients if they are ready to say goodbye. Sometimes they are willing to and sometimes they are not; if not, the reasons for not doing so are explored and respected. While saying goodbye may ultimately be a better solution, Tobin will allow patients to defer making this kind of resolution, but he does want them to take responsibility for making that decision. These scenarios may need to be repeated over a number of sessions before all of the issues can be worked through (Fodor, 1987).

Goulding and Goulding (1997) added to this some specific procedures that they use when the patient is saying goodbye to a deceased person. They have the patient conjure up a scene from the past in which the person was still alive. They do not want him or her talking to the individual as a dead person because this will weaken the attempt to break the connection. They then ask the patient to bring up the image of the person as dead and say “you are dead” and “goodbye” (Goulding & Goulding, 1997, p. 146).

**Internal Dialogues**

Internal dialogues are seen as useful when pa-
tients experience conflicts between different parts of themselves, when they are of “two minds,” or when they are “at war with themselves.” The distin-
tinction between internal and external is not hard and fast in actual practice because some of the disturbing internal voices are actual introjects of parental figures (Perls, 1973). Dialogues that begin within a person may evolve into encounters with people from the past. Nonetheless, there is a class of situations that can be seen as primarily internal, and clinical examples can be grouped into several subcategories. Greenberg et al. (1993) developed a therapy that specifically addresses the issue of inner conflict. They, as do others in the Gestalt tradition (Fagan et al., 1976), call these “splits.” Splits or conflicts often involve issues of desire and criticism or of desire, fear, and criticism.

In many cases, these kinds of situations involve a harsh and critical voice (also known as the “inner critic”). In Greenberg’s (R. Elliott & Greenberg, 1997; R. Elliott et al., 1998; Greenberg et al., 1993, 1998) model, one chair embodies the critic, and the person speaks from this perspective while in the chair. In the other chair, which is known as the experiencing chair, the person expresses how it feels to be criticized. Greenberg et al. (1993) presented a case in which a writer entered therapy suffering from, among other things, depression and procrastination. In the first series of chair dialogues, it became clear that as the inner critic made its demands, she retreated and avoided. In this way, her procrastina-
tion is a way of coping with these harsh inter-
nal voices. Later in treatment, she was able to have dialogue between the critic and the creative side of herself. Here it emerged that the critic was actually frighted of the creative side; she was afraid that it would be overwhelming. The creative side, in turn, was fearful that the critic would destroy her. When she was finally allowed to emerge, it was often with such force that the critic felt overwhelmed. In keeping with the Gestalt emphasis of integration, the patient reported that she was beginning to be able to balance these forces more effectively, that she could let the creative side out “in moderate doses” and end the “either/or situation” (Greenberg et al., 1993, p. 309). While these splits often involve the use of two chairs, they can involve more. One patient developed a three-way dialogue between his developing assertive self; a critical, repressive, and moralistic voice that he connected with his father; and a fearful, anxious voice that he connected with his mother. The resolution in a situation like this could involve expressing one’s desires and creating plans to act on them while also clarifying one’s moral code and being cognizant of realistic dangers that might exist.

Inner critic issues relate to Perls’ (1973) discussion about introjection versus assimilation. Using Perls’ food metaphor, in introjection, the child takes in the parent’s values as a whole, without examining or questioning the contents. With assimilation, there is a “digestion” process in which the child retains those things that are of value, importance, or use, and lets the rest go. This is an integrative process, not an all-or-nothing process. These dialogues enable this assimilation process to occur.

A second type of internal conflict is what Perls (1973) called a retroflection and what Greenberg (1979; Greenberg et al., 1993) called a “self-interruptive split.” In this situation, one part of the person does something to another part of the person. Adapted examples from Greenberg (1979) are “I judge myself”; “My difficulty is that when I’m writing my paper, I’m also marking it”; and “I close off my feelings. I don’t allow myself to feel” (p. 318). Again, the chairwork involves putting the part that is interrupting in one chair and the part that is seeking expression in the other.

One may also be of more than “two minds” about something. Young et al. (2003) developed mode therapy, a variant of schema therapy, to address the problems experienced by individuals with severe character disturbance—particularly borderline and narcissistic personality disorders. They see the inner world of these patients as being populated by a number of inner figures including the vulnerable child, the angry child, the detached protector, the punitive parent, and the healthy parent. While Young et al.’s model involves a great deal of imagery work, there is also an opportunity for these aspects of the self to engage in dialogue so that they can work together to both stop the damaging impact of the punitive parent and function better in the world.

Another kind of inner dilemma can be found around decisions. Indecision may reflect a conflict between two values (Fabry, 1988), or it may be connected to different aspects of one’s past or different projections about one’s future. Decisions to stay in a relationship or leave, to take a new job or stay in the current one, to allow a child to take a year after high school or insist that he or she attend college immediately may not have a clear right or wrong answer. Having each chair represent a side of the argument and having the patient speak from that perspective (“I want to stay in my current job,” “I want to take the new job”) can help him or her get a clearer sense of the emotional valence of each side as well as some historical factors and introjects that may be contributing to the indecision. “Is economic security the key issue or would it be better to pursue that which I am passionate about?” Young et al. (2003) believed that these conflicts may be connected to schemas or modes, and they frequently gave names to the different perspectives or the different selves that have emerged in the work.

This kind of approach is also applicable to procrastination. Goulding and Goulding (1997) reported a case in which a patient was procrastinating in the completion of her dissertation. As she worked with “I want to write” and then “I won’t write,” she realized that her anger at her parents was playing a role in her lack of productivity. The therapists, so as not to recreate her dynamic with her parents, left it up to her as to whether she would take action to complete the dissertation or not.

One variable that can be of value here is that of time (Goulding & Goulding, 1997). In the discussion on abuse above, the adult patient spoke to himself when he was a child. In blocked decision-making situations, it can be helpful to speak about the decision from a future time perspective; that is, patients can speak about how their life is
1, 5, 10, or more years from now, given that they had made a specific decision. Patients can be prompted to explore the impact of the decision on specific areas of their lives. “You decided to take that job and it is now 5 years later. How are you doing financially? How is your family? Your marriage? How is your health? Your sexuality? Your sense of self? How do you feel about not having made the other decision?” This can then be done with the person sitting in the chair that represented his or her decision to not take the job.

Another “internal” dialogue is one between the individual and various body parts or diseases. In an era in which there are both high levels of cultural emphasis on body perfection as well as an mind–body approaches to healing, this would certainly appear to be an approach worth exploring. Young et al. (2003), again using a combination of imagery and dialogue, described a case of a physician who had been in therapy for 20 years in an attempt to address his concern that he had a “migrating tumor” (p. 83). The patient was asked to imagine the tumor and then have a dialogue with it. The tumor said that the patient “has not been doing his best work and is very bad. The tumor is in his body to punish him. Paul [the patient] had better work more conscientiously or the tumor will strike him dead” (Young et al., 2003, p. 83). The patient was then asked to bring up an image of someone in his life who had treated him the same way, and he recalled a situation in which he, as a child, was being confronted by his extremely demanding father. The therapist concluded that “like the tumor, the father embodies Paul’s Unrelenting Standards schema” (Young et al., 2003, p. 83).

Cummings (1999) wrote about the value of Greenberg’s (Greenberg et al., 1993) process-experiential therapy in the treatment of patients with genital herpes. First, she noted that the two-chair intervention could be quite appropriate for helping clients resolve a number of internal, confictual splits of the self engendered by the disease: e.g., being a good versus bad person, feeling out of control versus gaining self-control, self-blame versus other blame. (p. 147)

This could include using the empty chair to speak to the person who transmitted the disease to them. It could also be used to practice telling a new partner that they have herpes. In her case example, Cummings encouraged the patient to put her herpes in the other chair and gave her the opportunity to express what she wanted and needed to say. At the beginning of treatment, the patient was deeply distraught about having herpes, but after some sessions that included the use of chair dialogues, she felt that she had resolved the issue and wanted to move on to other topics.

Corrective Approaches

While the dialogues here are also internal, the structure is somewhat different. This use of chairwork is centered in the cognitive–behavioral approaches and is also found in schema therapy. It grows out of the disputation tradition and involves the patient first expressing the dysfunctional thought or schema in one chair and then countering it in the other. In a sense, this is the most directed use of chairs, in that the therapist may purposefully work with patients to create a dialogue that counters the dysfunctional one.

Elliott and Elliott (J. E. Elliott, 1992; J. Elliott & Elliott, 2000) have developed anthetic therapy. Anthetic therapy, like Ellis’ rational– emotive behavior therapy (Ellis, McInerny, DiGiuseppe, & Yeager, 1988), interweaves techniques for healing with the adoption of a humanistic philosophy of life. The Elliotts believe that most psychopathology and psychic anguish comes from the “inner critic,” a punishing, judgmental inner voice that seeks to control the individual. The core technique in this work is the anthetic dialogue. In a recent formulation of this approach (by Elliott & Elliott), the patient describes his or her problem and the view of the inner critic is elicited. This view is typically filled with “shoulds” that the individual must follow or that lead to an experience of emotional pain. The inner critic is then put in one chair and the patient sits in the other and defies the critic by affirming that he or she has the right to do whatever is being prohibited. By defying these critical injunctions, the patient regains the ability to behave freely, in a manner based on his or her values and beliefs, rather than out of fear.

Working from a cognitive–behavioral perspective, Goldfried (1988, 2003; Samoilov & Goldfried, 2000) made the case that both clinical practice and neuroscience are pointing to the importance of “hot” or emotionally laden cognitions in the change process. He viewed the incorporation of chairwork into cognitive–behavior therapy as a way to more effectively change patients’ cognitive structures. Patients are invited to engage in a dialogue between the “realistic” and “unrealistic”
parts of themselves. They are also told that this is a way of “taking what is internal and implicit and making it external and explicit” (Goldfried, 1988, p. 65). Again, the purpose is to enable the patient to experience emotional arousal so that his or her cognitive structure is more amenable to change.

Young et al. (2003) built on this tradition by helping the patient engage in a dialogue with his or her schema. Again, the schema is a trauma-related vision of the self and the world. The patient states the rules in one chair and then refutes them in the other by providing contradictory evidence. Schema therapists will often encourage the patient to take the role of the schema first, while the therapist takes the healthy role. They then reverse positions. Eventually, the patient can enact both sides of the dialogue.

In a case example, a patient named Daniel was presented. His background included alcoholism in his father and sexual, physical, and emotional abuse at the hands of his mother. His primary schemas were Mistrust/Abuse and Defectiveness. In short, he had doubts about his worth and he was extremely mistrustful of others. He had a goal of developing a long-term relationship with a woman, but his schemas were interfering. In their treatment of this patient, Young et al. (2003) first worked with the patient to develop arguments against the schema. These were then put to the test. An imaginary scenario was created in which the patient saw an attractive woman at a dance that he wanted to approach. First, the schema side was encouraged to speak, and then the healthy side took a turn. For example, the patient, sitting in the schema chair, said, “Women can’t be trusted, and they’re very unreasonable and erratic, and it will be very difficult to figure out just what to do. And I don’t think you can do it.” He then responded in the healthy chair by saying, “Women are people just like men are, and they can be very reasonable, and they’re very nice to be with” (p. 103). Young et al. emphasized the importance of having the healthy self counter every argument of the schema side. The patient goes back and forth until the healthy side wins. It may be necessary to replay this scenario many times before the patient fully incorporates the healthy side. Repetition may be particularly important because the patient may first accept the new perspective intellectually but not emotionally; the goal is to have the patient eventually accept it on an emotional level.

In a case with a similar structure, a patient named Ivy was presented. She had a Self-Sacrifice schema, which meant that she put the needs of others before her own. This was done to such an extreme that it was causing her to feel angry and depressed. She was specifically angry at her friend Adam because she felt that she listened to all of his problems while he did not show an interest in hers. The dilemma was whether to bring this up with him or not. She did chairwork between the schema side, which said that she needed to take care of him, and the healthy side, which wanted a better balance, in which her needs were met as well. As part of her change process, she got angry at the schema. After finishing the dialogue, she did imagery work in which she brought up childhood images of taking care of her mother. She took further steps to let go of the schema by telling her mother, “It cost me too much to take care of you. It cost me my sense of self” (p. 148).

Again, this approach contrasts with the “unfolding” perspective of the Gestalt or process-experiential therapists. Young et al. (2003) believe that the more troubled the patient is, the less available are the healthy schema and mode voices; in a sense, that is a core aspect of their disturbance. This means that the patients are frequently unable to generate these kinds of dialogues on their own, and the therapist must work with them to create and nurture these voices and perspectives.

Dreams

Perls (1969a, 1973, 1975) strongly believed in the importance of working with dreams as a way to transformation. In his writings and in the transcripts of his work, he emphasized that the dream is a creation of the individual and that each aspect of the dream represents a part of the person. In the therapeutic encounter, the patient is asked to tell the dream in the first person as if it were actually happening at the present moment. The patient is then asked to change chairs and speak from the perspectives of the various people, animals, or objects that occurred or played a role in the dream. The goal here is integration. As Perls (1975) said,

My dream technique consists of using all kinds of available material that is invested in the dream. I let the people play the different parts and, if they are capable of really entering the spirit of the part, they are assimilating their disowned material. (p. 137)
A central aspect of this, which is discussed below, is the eliciting of polarities or opposites from the image within the dream. This is quite clear from an account by Miller (1992), who described a dreamwork session by Perls in 1966:

I also remember my surprise as I watched a vastly overweight mental health worker burst into sobs of deep grief within moments after Perls asked her to imagine that she were a beached whale. The whale had appeared in a dream about marine life that she had just recounted. With prompting from Perls, she seemed to melt before our eyes into a neglected child alone in her room, bitterly lamenting the emptiness of her existence. Usually this sort of Epiphany occurred, if at all, only after a long spell in therapy. When Perls told her, as her tears dried, to become the sea in her dream, her huge shape seemed for a moment not just the visible burden of her self-hatred but an indication that she could be teeming with life. (p. 2–3)

At their most stark, these are images of death and life, of deprivation and abundance. Perls was able to both acknowledge and help the mental health worker experience her suffering while also revealing her potential for growth and creative possibility.

Redecision therapists also feel free to work with dreams in an imaginative and fluid way. If a dream is interrupted, they will have the patient finish it in a positive and empowering fashion. This is also true for dreams that recur. Massé (1997), in an article on PTSD, wrote about a veteran who had a repeated nightmare in which he was walking down a path while a Vietcong soldier was waiting to kill him. She created a chairwork scenario in which “he became a tree along the trail, and told both himself and the Vietcong that the war was over and they both could go home now. Both agreed to put down their weapons and go home” (p. 206). That was the last time he had that dream.

**Integrative Possibilities**

There have been a number of attempts to integrate cognitive–behavioral and Gestalt techniques and approaches. In addition to the work by Goldfried (1988, 2003; Samoilov & Goldfried, 2000) and Young et al. (2003) discussed above, Fodor (1987, 1996) described an “integrated Gestalt/CBT approach” (p. 212) in which she utilized a wide range of Gestalt and experiential techniques, not just chairs. In turn, Wolfe and Sigl (1998) incorporated some cognitive–behavioral techniques in their process-experiential work.

More recently, Chadwick (2003) purposely modified and integrated Greenberg’s (Greenberg et al., 1993) two-chair approach within a schema framework for the treatment of psychotic patients. This constructivist approach is based on the idea that the lives of patients suffering from psychosis are dominated by a negative schema, a schema that develops both from their negative life experiences as well as the criticisms of their hallucinatory voices. Chairwork is done to help create a positive schema, a schema that reflects their healthy and good experiences and their affirming relationships. The goal is not to replace the negative schema with the positive one but rather to provide the patients with a more complex sense of self. This means that they will begin to realize that they are not just “bad” but that they are also “good” and that both schemas have meaning. As they create a new self-construction, they will begin to process their life experiences in a richer manner, a manner that will hopefully result in beneficial changes over time.

In terms of developing a working model for the use of chairs in cognitive–behavioral therapy, there are four core ideas that can be of use. The first is that gestals are schemas; these are merely different words for the same phenomenon. As Fodor (1996) wrote, “Schemas are dynamic knowledge states, (gestals) that organize experience” (p. 34).

This is a useful view, in part because it opens up the possibility of using Young et al.’s (2003) schema language when describing a patient’s gestalt framework. For example, in a Gestalt therapy case presented by Zahm and Gold (2002), the patient, Kim, became aware of a set of internal rules governing needs and emotions. “Kim had learned not to reveal her feelings and emotional needs, but rather to focus on taking care of her mother and siblings, and deal with any of her needs by herself” (Zahm & Gold, 2002, p. 869). These realizations are a very close match to the schemas of Emotional Inhibition and Self-Sacrifice (Young et al., 2003).

The next point is that the challenging and transforming of dysfunctional schemas is a core goal of both forms of treatment (Greenberg et al., 1989). This can be conceptualized in several ways. Both Beck (Dattilio & Freeman, 1992; Young, Beck, & Weinberger, 1993) and Ellis et al. (1988) share the view that the cognitive structure underlying emotional distress is typically distorted and extreme. Therapy involves the
some aggression is being projected somewhere. Person who says he is frightened: you can be sure watching said, response to both the patient and the group that was just aware of being frightened.

Perls (1973, 1975), in many respects, shared the same goal. Perls believed that patients already have everything that they need within them. Because of unfortunate life experiences, they have disowned vital aspects of themselves and projected these abilities onto others. As can be seen in the dreamwork example above, the goal of therapy is to reclaim these projections, to integrate them into the self, and to achieve a state of centeredness. Through the chair dialogues, the patient is able to create an integrated synthesis and an expanded repertoire of behavior. He or she can then both work and play; he or she can exist in solitude and be a member of a group.

In the transcripts of his work, Perls (1969a, 1973, 1975; Rosenberg & Lynch, 2002) is frequently using chairs to take the polar opposite view as a way of reclaiming these energies. At the beginning of one session, a patient said, “I’m just aware of being frightened.” Perls, in a response to both the patient and the group that was watching said, “So attack me right away! The person who says he is frightened: you can be sure some aggression is being projected somewhere. So attack me!” She responded, “I am more aware of feeling fear from—the group than you.” He countered, “So attack the group! Tell them what lazy bums they are” (from a Perls therapy transcript cited in Rosenberg & Lynch, 2002, p. 186).

In this process, Perls was helping the patient connect with and affirm an assertive aspect of herself that she had denied and projected.

When we look at polarized thinking from both perspectives we can see that, if patients feel that they do not have access to the parts of themselves that are strong or aggressive, then the consequent vulnerability and anxiety may well fuel the rigidity and intensity of the dysfunctional beliefs. The integrative possibility, then, is that therapists could now use chairs to try to alter schemas and dysfunctional thinking not only through the use of the corrective techniques (J. E. Elliott, 1992; Elliott & Elliott, 2000; Goldfried, 1988; Young et al., 2003) but also through the use of the polarity approach (Perls, 1973, 1975).

Given that gestalts are schemas and the schema change is a central goal of the therapeutic enterprise, Edwards’s (1989) perspective is of central importance. He made the third point that Perl’s psychodramatic work with both chairs and imagery was, in fact, a form of cognitive restructuring. This, in essence, ties together all of the different visions of chairwork that have been reviewed in this article.

Finally, a pragmatic or unifying metaphor for the use of chairwork in psychotherapy may be R. E. Elliott and Greenberg’s (1997) article on voices and multivocality. Psychotherapy can begin to be seen as a process of strengthening, transforming, and creating “voices,” of enabling patients to engage in healing inner dialogues and of helping them to create a new hierarchy within themselves (Fosdick, 1977; Kellogg, 1993) so that the more adaptive and empowering voices have greater weight than the trauma-based or dysfunctional ones.

Conclusion

Further dialogues among cognitive–behavioral and schema therapists, on the one hand, and Gestalt, process-experiential, and redecision therapists, on the other hand, have the potential to lead to even more creative and effective ways of changing lives. While it seems highly probable that imagery and chairwork, and the theories behind them, will continue to be reenvisioned by the cognitive and schema therapists (as they have been in this article), the field of psychotherapy will be much richer for having integrated the wisdom of the Gestalt approach.

References


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