

CITATION: This chapter is an extract from the following book –

Pugh, M. (2019). *Cognitive behavioural chairwork: Distinctive features*. Oxon, UK: Routledge.

## **24. Using Chairwork to Resolve Ambivalence and Enhance Motivation**

Ambivalence about change is associated with poorer outcomes in action-based therapies like CBT (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 generated promising outcomes (Marker & Norton, 2018). Experiential interventions provide an additional means to resolve ambivalent attitudes and strengthen commitment to change (Pugh & Salter, 2019).

### ***Therapist stance***

Therapists' style of facilitation when using chairwork to resolve ambivalence requires consideration. Generally speaking, an active, directive manner of facilitation is recommended when addressing indecision related to psychopathology (e.g. ambivalence about substance misuse). In these circumstances - and consistent with the principles of MI - therapists aim to elicit and selectively reinforce change-talk during motivational chairwork, whilst simultaneously accepting and 'rolling with' counter-change talk. However, if ambivalence is unrelated to psychopathology (e.g. uncertainty regarding innocuous decisions and life-choices), a more impartial, facilitative stance is appropriate.

### ***Assessing readiness to change***

Clients' attitudes towards change can be assessed using chair-based representations (CRIB) (Pugh, in press). This intervention involves the client placing a chair, symbolising the focus of ambivalence, somewhere in the room representing its significance: the closer this chair is to the client's seat, the more important the subject/object of ambivalence currently is. This exercise can be taken in different directions, as the following transcript illustrates:

*Jane is exploring her attitudes towards recovering from her eating disorder.*

Therapist: Imagine this chair represents anorexia. How close is it to you in life right now?

Jane: Very close, about here. [*Jane places the chair an inch from her own*].

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. It also gives me something to think about so I don't feel lonely.

Therapist: And the bad sides?

Jane: [*Thinking*]... I guess I don't have the energy for much else.

Therapist: What if we moved anorexia a little further away? [*Therapist moves the chair a few feet from Jane's seat*]. Would that come with 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 more.

Therapist: So if creating a little distance from anorexia seems helpful, what steps would help 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 presents their reasons for and against change from different chairs. They then move between these seats, responding and counter-responding from both perspectives, until ambivalence seems more resolved<sup>1</sup>. At the end of exercise, the client stands and reflects on their feelings towards the sides which have spoken. If feeling more decided, I usually ask them to conclude the dialogue by sitting in the chair representing their decision and stating their reasons for doing so.

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.

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 feel proud when I lose weight. Not everyone can do that.

Therapist: [*Coming alongside sustain-talk*]. Anorexia makes me special.

Jane: Exactly. It makes me different.

Therapist: [*Amplifying sustain-talk*]. And being different is the most important thing in life.

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

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

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

Therapist: Sounds like the other side is coming out now. Can you switch? [*Jane moves to chair two*]. So this part thinks, “I want to change because life with anorexia feels empty” [*Reflecting change-talk*]. Is that right?

Jane: Yeah. Life's so boring when everything revolves around food.

Therapist: [*Affirming change-talk*]. I can understand why you get tired of that.

Jane: I do.

Therapist: [*Elaborating change-talk*]. What else does this side think? What other problems come with anorexia?...

*Jane speaks from both chairs until her feelings about recovery seem 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?

Jane: I was definitely more 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*].

Therapist: How would you rate the relative strength of each side right now? 50-50? 60-40?

Jane: 80% in favour of changing.

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

*Jane goes on to outline her reasons for recovery.*

In other situations, 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") are a more appropriate means to encourage decision-making.

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 strongest side, the client then expresses their positive attitudes towards the subject/object (chair two) and their negative attitudes (chair three). Once these polarised attitudes and emotions are fully expressed, the dialogue concludes with the client formulating a decision about how their relationship with this 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 of you shall we begin with - the side which feels positively towards drinking or negatively?

Kabir: The side that's grateful for alcohol.

Therapist: Let's start in that chair. [*Kabir moves to chair two*]. From here, tell alcohol what you're grateful for.

Kabir: [*To the empty 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.

Therapist. Let's move to the other chair in then. [*Kabir moves to chair three*]. Speak from your sadness, Kabir. Tell alcohol about the negative feelings you hold towards it...

*Kabir goes on to outline 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 reflects the implementation of decision A is enacted (e.g. "My future self as if I were still using drugs"). Next, the client embodies their 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 in relation to how their life has unfolded in key domains (e.g. health, relationships, and finances). After both enactments, the exercise concludes with the client reflecting upon which 'future self' feels most appealing and consistent with their values and aspirations.

Therapist: Imagine your future self in this chair as if you still had anorexia in 10 years' time. [*Introduces chair one*]. How you picture this version of Jane?

Jane: She looks tired and frail.

Therapist: What do you imagine she's feeling?

Jane: Mostly numb... But deep down she's lonely.

Therapist: How would she sound when she spoke?

Jane: Pretty quiet, I guess. Weak too.

Therapist: Let's get to know this version of Jane. Can you change seats and be this future self? [*Jane moves to chair one*]. Nice to see you again, Jane. How have you been these last 10 years?

Jane: Not great. I'm still unwell.

Therapist: I'm sorry to hear that. How are you managing?

Jane: Pretty badly. My osteoporosis is worse. I haven't seen my friends in years. My family have pretty much given up on me. [*Becomes tearful*]...

*Jane describes daily life for her future self in other domains.*

Therapist: ...Life sounds tough, Jane. If you could go back in time and speak to your self when you were contemplating getting better, what advice would you give? [*Gestures to Jane's original chair*].

Jane: [*To the empty chair*]. Continuing to live with anorexia is misery, Jane. You need to get better.

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.*

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 relaxed. She's happy.

Therapist: Can you step into her shoes? [*Jane moves to chair two*]. Great to see you again, Jane. I can't believe it's been 10 years already. How are you?

Jane: Great! I'm married, I'm running my own store, I even have children.

Therapist: Fantastic! Last time we spoke you felt unsure about recovering from your eating disorder. How did you feel about your decision to recover now?...

### ***Strengthening commitment***

'Decision dialogues' are used 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 ambivalence, represented by an empty chair. This statement of commitment 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 the problems his alcoholism has caused.*

Therapist: ...Now tell alcohol what you've decided.

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

Therapist: How do you imagine alcohol responds to that? [*Gestures to the empty chair*].

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

Therapist: Tell alcohol what's going to sustain your strength and how you're going to begin this process of change...

Playing 'devil's advocate' is another well-known technique for strengthening commitment. This involves the therapist presenting the reasons against change (chair one) whilst the client argues in favour of change (chair two).

Therapist: So you've decided to start reducing your exercise?

Jane: Yes. I'm ready.

Therapist: That's brilliant, Jane. Let's use the chairs to strength your commitment to this decision. I'm going to argue in favour of using exercise as a safety behaviour and I'd like you to argue against. [*Therapist changes seats*]. Ready? [*Jane nods*]. You need to exercise before you eat tonight.

Jane: I don't. Nothing bad will happen if I eat without exercising.

Therapist: It'll help you feel less anxious.

Jane: Exercise only keeps my anxiety going. I need to test out whether it's really necessary.

Therapist: You can't reduce your exercise.

Jane: Yes I can! I will!...

Should the client struggle to present reasons in favour of change during this dialogue, coaching is not provided as this risks eliciting counter-change talk (Burns, 2018b). Rather, 'stuckness' signals the client's ambivalence is not fully resolved and commitment-focused interventions have been introduced prematurely.

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<sup>i</sup> Therapists sometimes observe that two-chair decisional balancing transforms into dialogues between dominant-coercive parts of the client (e.g. "I should study more") and submissive-coerced self-parts (e.g. "But I want to spend time with my family") (Kellogg, 2015). In these situations, chair-techniques for working the critical or demanding parts of the client may be more appropriate.