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Chapter 8

Chairwork in schema therapy: Applications and considerations in the treatment of eating disorders

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Schema therapy integrates techniques from cognitive, behavioural, gestalt, and psychodynamic approaches to treat complex and treatment-resistant psychological difficulties. Experiential interventions such as imagery rescripting and chairwork are amongst the most effective methods for bringing about schema-level change and have been centralised in schema therapy (Young, Klosko, and Weishaar, 2003). This chapter provides an overview of chairwork techniques utilised in schema therapy and describes how they can be applied in work with eating disorders (EDs). The chapter begins with an introduction to the format and process of chairwork. Key chair-based techniques are then described alongside illustrative extracts from schema therapy sessions. Common obstacles which can arise when using chairwork with ED cases, and recommendations for resolving these issues, are lastly discussed.

Introduction

First conceived over one century ago, ‘chairwork’ represents a collective of established experiential techniques which utilise chairs and their relative positions to facilitate therapeutic dialogues

(Pugh, 2017a). Chairwork techniques were first utilised within the psychodrama approach (Moreno, 1948) and later gained wider recognition within gestalt therapy (Perls, 1973) before being more rigorously evaluated within emotion-focused therapy (Greenberg, 2011). Chairwork has since been incorporated into other evidence-based therapies including cognitive-behavioural therapy (Pugh, 2017b, 2018), compassion-focused therapy (Gilbert 2010), and schema therapy (ST; Young et al., 2003; Arntz and Jacob, 2013). Whilst research is yet to determine the efficacy of schema-focused forms of chairwork, chair-based techniques utilised in other approaches have proven clinically effective in addressing multifarious clinical issues (e.g. Butollo et al., 2016).

The four dimensions of chairwork: Focus, form, facilitation, and frame

Chairwork techniques have been categorised along various dimensions. Regarding *focus*, chairwork in schema therapy seeks to modify early maladaptive schemas (EMS), dysfunctional schema modes, and/or maladaptive patterns of behaviour (i.e. schema coping styles). In terms of *form*, ‘empty-chair’, ‘multi-chair’, and ‘role-playing’ techniques are most often used in ST (Kellogg, 2004). Empty-chair techniques involve the client speaking with an ‘other’ who is held, symbolically, in the empty chair (for example, a maladaptive schema mode or caregiver associated with the development of an EMS). ‘Two-’ or ‘multi-chair’ techniques involve the client moving between multiple seats representing different parts of the self. Lastly, chairwork role-plays involve the therapist and client re-enacting self-to-self or self-to-other relationships. Conceptualised differently, Kellogg (2015) has delineated two types of chairwork: “*internal dialogues*” which involve the client giving voice to parts of the self, and “*external dialogues*” involving the client speaking with significant others.

When applying chairwork techniques, schema therapists *facilitate* two types of dialogue. Exploratory or ‘diagnostic’ chairwork exercises aim to explore and better understand schemas, modes, and their dynamics (Kellogg, 2015). For example, the therapist might ‘interview’ a schema coping mode regarding its aetiology and function (Therapist: “Detached protector, can you tell me how you help this individual?”). In contrast, ‘transformational’ or directed chairwork dialogues aim to achieve specified

outcomes. For example, schema dialogues (Young et al., 2003) seek to reduce conviction in an EMS whilst simultaneously building the client's 'healthy' internal voice.

Finally, chairwork allows individuals to re-examine internal and external events through the lens of new, embodied perspectives (a process sometimes referred as changes in '*frame*' [Villatte, Villatte, and Hayes, 2016]). These 'frames' might involve exploring events using new 'interpersonal' perspectives ("If your punitive parent mode chastised *someone else* that you care about in this way, what would you say to it?"), 'intrapersonal' perspectives ("How could you respond to your schema from your *other, healthy, side*?"), 'temporal' perspectives ("If you could go back in *time*, what would you want to tell your child self about the abuse they suffered?"), 'spatial' perspectives ("Would you like to try *standing* as you confront your punitive mode?"), and 'analogous' perspectives ("Which of these pictures best *represents* your detached protector in the empty chair?").

Process-related skills

Schema therapists maintain an active role-play during chairwork and use process-based skills to stimulate change. These moment-by-moment interventions help clients immerse themselves in the dialogue, connect with internal states, and establish a sense of agency to maximise the effects of chairwork. Equally, schema therapists attend to their role in the dialogical process - at times prompting the client, actively intervening at other points, and sometimes remaining silent - to ensure the intervention reaches a therapeutic conclusion. Key process-related skills are summarised in Table 1. For detailed guidance, readers are referred to Greenberg (1979), Kellogg (2015) and Pugh (2017b, 2018).

Chairwork and Eating Disorders

Preliminary findings suggest that chairwork techniques may be particularly effective in the treatment of EDs (Dolhanty and Greenberg, 2009; Pugh and Salter, 2017). Several reasons might

explain the efficacy of chairwork in work with EDs. These include concretising abstract concepts such as ‘multiplicity of mind’, facilitating shifts in perspective, encouraging emotional expression, and differentiating complex affective states, all of which can be challenging for this group. Chairwork also provides an effective method for resolving distressing events in childhood so can provide an alternative to imagery rescripting if this is not viable. Lastly, schema therapists employ process-skills to ensure that chairwork can overcome impairments in emotional regulation and meet each individual’s needs.

Schema-focused chairwork

Assessing maladaptive schemas

Standard methods for assessing EMS such as imagery assessment (Young et al., 2003) and self-report inventories are complimented by chairwork. For example, chairwork role-plays can be used to identify which EMS become activated in problematic situations. By recreating these events, the therapist and client are better able to ‘feel’ and name underlying schemas.

Therapist: That sounds like a tough situation at work, Susie. Could we re-create the meeting you had with your manager? It might help us identify which schemas came up for you.

Client: Ok.

Therapist: Great. Let’s change seats and, when we do, I’ll play your manager and I’d like you to respond the way you did at work.

Therapist and client move to new seats.

Therapist: Susie, your performance this month has been unacceptable. This is the second time your sales have fallen.

Client: I’m trying my best. Perhaps my performance fell because I took some sick leave.

Therapist: Enough excuses, Susie! You need to take responsibility for yourself! [*Client becomes tearful*]. Ok, let’s pause there. You look really upset, Susie. What’s happening for you?

Client: I feel really horrible.

Therapist: What's running through your mind right now? What are you saying to yourself?

Client: I'm a complete failure. I'll never get anywhere in this job.

Therapist: That sounds really painful. I can understand why you feel so upset if you're thinking about yourself in that way. Do you often see yourself as a failure?

Client: Always.

Therapist: And what do you feel like doing as you're thinking that?

Client: I want to hide away in my bedroom. I want to binge.

Therapist: I see. So this situation is triggering a belief about being a failure, is that right? [*Client nods*]. I wonder if binge-eating and withdrawing is something you often want to do when this schema gets activated? Like it's a way of coping with those feelings?

Modifying maladaptive schemas

Compared to other clinical groups, EMS are particularly pronounced in the EDs (Pugh, 2015). Accordingly, addressing EMS plays a vital role in reducing distress and ameliorating disordered eating. A powerful method for re-evaluating the accuracy of EMS is 'schema dialogue' (Young et al., 2003). This intervention, sometimes referred to as 'point-counterpoint' in schema-focused CBT (Young, 1990), involves a two-chair dialogue between the 'voice' of the client's EMS and their healthy side. In contrast to more spontaneous mode-focused dialogues between parent modes and the healthy adult mode, schema dialogues are preceded by a thorough examination of the evidence which supports the EMS which is then re-appraised. This cognitive work is then made more visceral and evocative through the use of chairwork. First, the client is asked to present evidence supporting the schema in chair one whilst rebuttals are provided by the therapist (enacting the client's healthy side) in chair two. Once the client has developed skill in formulating healthy counter-arguments, they are encouraged to play both roles: the client presents a single piece of evidence supporting the EMS in chair one and then challenges this evidence in chair two (with coaching from the therapist). Finally, schema dialogues may incorporate a final provocative step, sometimes referred to as the 'devil's advocate technique' (Goldfried, Linehan,

and Smith, 1978). In this stage, the therapist enacts the schema (chair one) and actively challenges the client's healthy statements (chair two). If the client becomes stuck, the dialogue is paused so that convincing counter-arguments can be collaboratively constructed. It is worth noting that encouraging the client to get angry at their EMS can also stimulate change during schema dialogues (Young, 1990): by expressing their anger at the EMS, clients not only challenge the content and utility of their schemas, but also acquire distance from these beliefs (Therapist: "Tell the schema what you resent about it").

The client and the therapist have been practising schema dialogues. The therapist now proposes using the 'devil's advocate' technique.

Therapist: You did really well during that dialogue, Susie. We are developing a really strong case against your emotional inhibition schema. Let's take this one step further. In a moment I'm going to change seats and enact your schema but I'm going to be more persistent this time. I'd like you to play your healthy side and convince me that what I am saying is not true. Let me know if you get stuck so I can help you generate a convincing counter-argument. Ready?

Client: I think so.

Therapist and client move to new seats.

Therapist: You shouldn't show people how you really feel. If your friends knew about how difficult eating can be for you, they would run a mile.

Client: That's not true. I told one of my friends about my eating disorder and I got quite upset, but she was really supportive. It's good to express how you feel.

Therapist: But no one wants to know how you really feel, do they? It's too much of a burden.

Client: ... [*silent*].

Therapist [*out of role*]: Tell me why sharing your feelings aren't a burden for others.

Client: When I tell others how I feel, I feel more connected to them. They are happy that I've opened up. They don't say I'm a burden, they say the opposite! ...

Addressing schema origins

Sadly, childhood maltreatment is common across ED subtypes (Caslini et al., 2016). As well as addressing the content of schemas, chairwork enables clients to confront individuals who have played a role in formation of an EMS. This often involves the client speaking with caregivers who were unable to meet their needs in childhood. Empty-chair and role-play formats can be used to facilitate such dialogues. Empty-chair techniques involve the client challenging specific individuals held in the empty seat. Historical role-play is a more elaborate intervention involving both the client and the therapist, and which involve three stages of enactment (Arntz and Weertman, 1999). First, the client (enacting their child self) and the therapist (enacting the parental antagonist) re-enact a troubling childhood event. Therapists may want to pause after this first role-play and - perhaps from a standing ('meta-') perspective - explore how this interaction between parent and child is wrong, inappropriate, and fails to meet the child's needs. Roles are then reversed in the second stage: by adopting the parental role, the client is able to garner new insights into the behaviours and validity of distressing messages conveyed by caregivers. Concurrently, the therapist is able to challenge these messages from the perspective of the client's child self. In the final stage, the client is invited to enact their child self once again and respond to their parent in more satisfying ways (with coaching, if needed).

Empty-chair technique:

Therapist: It sounds like the things your father said to you as a child have played a big role in seeing yourself as defective in some way.

Client: Yes. His comments about my body made me feel so ashamed when I was small.

Therapist: I wonder if it might be helpful for us to speak to him about this, in imagination.

Client: Ok.

Therapist: Take a moment to imagine that he is here, in this empty-chair. What do you see?

Client: I see him sat there, crossing his arms. He's looking at me judgementally.

Therapist: How do you feel seeing him?

Client: I feel angry.

Therapist: Tell him what makes you feel angry.

Client: I'm angry at how embarrassed and ashamed you made me feel about my body when I was small. It was wrong!

Historical role-play technique (stage three):

Therapist: I am going to change chairs and play your father once more, and this time I'd like you to respond to what I say from your healthy side.

Therapist and client move to new seats.

Therapist: You shouldn't eat as much as you do. Pretty girls keep an eye on their figure.

Client: I can eat as much as like. There is nothing wrong with me enjoying food.

Therapist: It's greedy and disgusting. You are behaving like a pig.

Client: I'm not a pig! I'm a normal human being and I am allowed to eat as much as I like!

Therapist [out of role]: Tell me why it's wrong for a father to say these things to a child.

Client: A father shouldn't speak to their child like this! It's wrong and makes me feel bad!

Constructing positive schemas

Surprisingly little has been written about how chairwork can elaborate positive schemas. Whilst modifying EMS plays an important role in ST, constructing positive self-beliefs may be equally important in bringing about lasting change (Brewin, 2006). Two methods can help achieve this. The first involves the client changing seats when an EMS becomes activated (i.e. decentering from the schema) and outlining positive events, achievements and experiences which do not support the schema (Therapist: "Try and leave the defectiveness schema in this empty chair and, from your new seat, describe some of the ways in which you are acceptable"). If this method proves challenging, the client can be invited to enact someone who views them in a compassionate light in order to elicit positive data (Therapist: "Susie, I'd like you to change seats and be your Auntie Mary for a moment ... Auntie Mary, Susie thinks of herself as worthless. As someone who cares deeply for her, can you tell Susie some things that you like and value in her?"). Chadwick (2003) has outlined an alternative, three-stage procedure for generating positive schema-level beliefs. A modified version of this technique combining

imagery work, which we have found particularly helpful in ST-ED, is outlined below. It is worth noting that, unlike schema dialogues, the positive and negative schema chairs do not speak to one another in this intervention: this is important, as the negative schema might easily overpower the newly constructed positive schema if such dialogues were to occur.

Susie has changed seats and is describing her lived experience of her 'failure' schema.

Therapist: How do you experience yourself when your failure schema becomes activated?

Client: I see myself as useless, like I've achieved nothing in life.

Therapist: And how does the future seem to you in moments like these?

Client: The future looks so bleak. I'm doomed to fail over and over again. I'll never recover.

Therapist: And how do you experience other people in these moments?

Client: Everyone around me seems so superior. I'm scared that they're going to humiliate me for not having a job or for having an eating disorder.

Therapist: It sounds like your mistrust schema is also active now. I'd like you to change seats, Susie.

[client moves seats]. Now let's take a moment to leave those schemas in your first chair and separate from them a little... Take a moment to just set them aside ... Now, I wonder, Susie, have there been any moments in life where you have experienced yourself as something other than a failure, even if it was just for a moment?

Client *[thinking]:* ... Well, I remember how I felt when I got my first job.

Therapist: Take me back to that moment. Tell me what happened. *[client describes the event in detail].* And how did you feel when the manager said she wanted you to join the company?

Client: It felt great. I was over the moon!

Therapist: How did others seem to you in that moment? What did the future look like?

Client: I felt like I was like everyone else, like I was achieving something. Other people seemed friendly and encouraging. It felt like I was moving on with my life. I was hopeful.

Therapist: Do you feel a little of that hope and happiness right now? Where do you feel it?

Client: *[touches chest].* I feel it near my heart. It's a warm feeling.

Therapist: Close your eyes for a moment, Susie, and really focus on that warm feeling... Allow it to get a little bigger if you can ... And now just see if any other memories come to mind when you felt something similar, like you were successful... What other memories do you notice?

Mode-focused chairwork

Mode assessment

Individuals with EDs present with multifarious and often conflicting schema modes (Pugh, 2015). Chair-based techniques enable the client and therapist to identify key modes and to ‘get to know’ these parts of the client better. This can be achieved by inviting the client to change seats and embody these maladaptive self-parts (see example below). Alternatively, modes can be interviewed by the therapist regarding their origins, functions, motivations, and intent (Artznz and Jacob, 2013). Intrapersonal role-plays are described in more detail later in this chapter (see section on the “eating disorder ‘voice’”).

Client: I tried to introduce the meal plan you suggested but I just couldn’t.

Therapist: Well done for trying, Susie. Do you have any idea what made it so difficult?

Client: I’m not sure.

Therapist: Let’s try an exercise to figure this out. To start with, can you remember what was running through your mind when you were considering trying out the meal plan?

Client: I think I was worried about what would happen to my weight.

Therapist: I see. Would you mind changing seats? [*client moves to a new chair*]. Now be that side of yourself, Susie. Really try and speak from that perspective.

Client: I’m really scared about eating more. What if I gain lots of weight and people think I’m really greedy? I just want to be normal like everyone else.

Therapist: Gosh, it sounds like your vulnerable child became really active when you thought about the meal plan. Does Little Susie feel strong in you right now?

Mode socialisation

Chairs can be used in creative ways to help clients grasp the schema mode concept and explore how modes interact. For example, the therapist might place a wall of chairs between their chair and a seat representing the vulnerable child to illustrate how coping modes (for example, the detached protector) block child modes and prevent them from experiencing the reparenting they need. Problematic events can also be reviewed from the perspective of different modes, held in different chairs, to elucidate the patterns of thinking, feeling, and behaving which each tends to generate. This technique can help identify modes which are most powerful or obstructive, whilst also highlighting the sequences in which modes tend to become activated.

Therapist: Last week we talked about how introducing a meal plan might help reduce your binges, but I got the impression that you had mixed feelings about doing that.

Client: Yes. I'm not sure I'm ready to try a meal plan yet.

Therapist: Ok. Can we try an exercise to explore what my suggestion brought up in you? I thought it might be helpful to explore what each of your modes think about the idea of regular eating.

Client: I'm not sure they were thinking anything, but ok.

Therapist: Great. Let me arrange a few chairs. *[Therapist arranges a small circle of chairs]*. I wonder what your vulnerable child - Little Susie - thinks about following a meal plan. Would you mind moving to this chair and speaking from the vulnerable side of yourself?

Client: *[Changes seats]*. I'm really scared about eating more food. It's going to be so difficult and I'm worried I'm going to gain weight. What if I get fat?

Therapist: I can see Little Susie is really worried about what might happen if you tried the meal plan. What about your punitive parent mode? What does that side think?

Client: *[Changes seats]*. I don't deserve to eat anything. I'm a fat slob and ought to starve.

Therapist: Gosh, that side of you can be so harsh, Susie. What about your overcontrolling mode? Change seats and be that side of yourself ...

Working with Wounded Child Modes

Vulnerable and angry child modes require particular attention in ST-ED (Simpson, 2012). Chairwork aims to give these parts of the client an opportunity to be visible, supported, and validated. Through enactment and embodiment, chairwork provides clients with a visceral connection to their child modes and so allows for a more powerful experience of re-parenting by the therapist. Given that many clients with EDs find expressing anger and sadness challenging, particularly when these feelings arise within the therapeutic relationship, many individuals will tend to suppress their emotional experiencing during chairwork (Geller et al., 2000). If this occurs, schema therapists will need to work with obstructive coping modes as precursor to more emotive dialogues.

Therapist: It sounds like you felt really sad before you binged, Susie. I can understand why given how hurtful the argument with your boyfriend was earlier on in the day.

Client: I guess so.

Therapist: Can you connect with any of that sadness right now?

Client: No. Not really.

Therapist: So right now you feel kind of...?

Client: Numb.

Therapist: I see. That sounds a little like your detached protector mode to me. I'd like to have a conversation with that part, if that's ok? Can you move over to this chair and be the protector? [*The therapist proceeds to negotiate contact with the client's vulnerable child mode*]. Thank you for agreeing to give Susie's vulnerable side a little more space to be heard today, detached protector. Susie, would you mind moving over to Little Susie's chair for a moment? [*Client changes seats*]. Tell me about how the argument with your boyfriend left you feeling, Susie.

Client: I felt so hurt and let down by him. He doesn't understand how hard it is for me to eat. I'm such a freak. [*Client begins to cry*].

Therapist: That sounds so hard, Susie. You suffer so much when you argue with him. But I want you to know that you are not a freak. I think you are a perfectly normal, acceptable human being...

Working with Demanding and Punitive modes

Compared to other clinical groups, demanding and punitive modes are often pronounced in the EDs (Nesci et al., 2014). Chairwork can be used to set limits on the demanding mode and fight the punitive parent mode. In terms of process, therapists will need to adjust their tone and stance depending upon which mode is addressed: a forceful tone is adopted when speaking with the punitive mode, whilst demanding mode is addressed in a firm but fair manner (Arntz and Jacob, 2013).

Multi-chair technique with the punitive parent mode:

Therapist: It sounds like your punitive mode was really attacking you yesterday, Susie. Can you change seats and be the punitive mode just for a moment? [*Client changes seats*]. Now, as the punitive parent mode, speak to Susie about the way she looks.

Client: You're a fat, horrible pig! Look at all those horrible rolls of fat. You look like a disgusting mess. [*Client becomes tearful*].

Therapist: Come back over to Little Susie's chair. [*Client changes seats*]. It really hurts when that side puts you down like that, doesn't it?

Client: It hurts so much. I just want to never eat again.

Therapist: You don't deserve this, Susie, not at all. I'd like to speak to your punitive mode, if that's ok? [*Client nods*]. [*Speaking to the empty chair*] You need to stop putting Susie down like this! She is fine just the way she is and you have no right to hurt her in this way!...

Working with dysfunctional coping modes

Research suggests that ED clients often have entrenched coping modes (Pugh, 2015), most notably Detached Protector, Avoidant Protector, Perfectionistic Overcontroller, and Self-soother modes

(Nesci et al., 2014; Voderholzer et al., 2014). In addition, many clients feel ambivalent about giving up these methods of coping given their apparent functionality. Accordingly, chair-based methods for negotiating with, ‘bypassing’, and developing motivation to ‘relax’ coping modes are vital in work with EDs. Relevant techniques might include exploring the costs (chair one) and benefits (chair two) of a coping mode using the decisional balance technique (Kellogg, 2015); asking the client to argue in favour of the coping mode whilst the therapist responds from the position of the healthy adult (Therapist: “I’d like you to outline the reasons why your avoidant protector is helpful and I will respond from the healthy adult perspective”) and then, later, reversing these roles; or encouraging the client to respond to coping modes from the perspective of evocative child modes to highlight their maladaptive consequences (Therapist: “Change chairs and be Little Susie... Little Susie, can you tell the Perfectionistic Overcontroller about how sad it sometimes makes you feel?”). Readers are encouraged to refer to the schema therapy literature for detailed guidance on bypassing coping modes (see Artanz and Jacob, 2013; Young et al., 2003).

Strengthening the Healthy Adult mode

Given that the Healthy Adult mode is often underdeveloped in ED groups (Volderholzer et al., 2014), therapists need to spend considerable time helping clients develop a supportive internal voice. Chairwork provides a potent vehicle for generating the self-directed kindness, encouragement and understanding embodied by the healthy adult (Gilbert, 2010). Various chair-based methods can achieve this. Initially, clients may find it easiest to strengthen their healthy adult mode by providing care and support to another individual held in empty-chair, as the following extract illustrates:

Empty-chair dialogue:

Therapist: Your mother’s remarks about your body shape must have really hurt, Susie. I wonder, is there a child you know and care about?

Client: I guess my cousin, Martha. She’s only nine.

Therapist: Ok, let's imagine little Martha in the empty chair. Can you imagine her sat there?

Client: Yes, she's very small. She'd be sat with her legs crossed, probably playing with her hair.

Therapist: Let's just imagine that Martha has been told by someone that she looks fat and horrible. What would you like to say to her to help her feel better?

Client: I'd tell her that she shouldn't listen to someone like that. She is perfect just the way she is. Her shape and weight don't matter. What matters is what is on the inside.

Therapist: That's lovely, Susie. You have such a caring side. Can you move over to Martha's seat now? [*Client changes seats*]. How do you feel hearing that? Are you able to connect with any of the things you have just said?

As well as using empty-chair techniques to practice vicarious re-parenting, two-chair techniques allow the client to practice giving and receiving care from a supportive individual they know:

Two-chair dialogue:

Therapist: Your mother's remarks about your body shape must have really hurt, Susie. I wonder, can you think of someone who has shown you care and kindness in the past?

Client: My grandfather, Tony.

Therapist: I'd like you to imagine your grandfather is sat in this other chair. How do you imagine how he might respond to hearing what happened to you?

Client: I think he would be concerned knowing how hurt I feel. He would want to help.

Therapist: How would he show his care? What would he want to do to help you?

Client: He would want to reassure me that I'm not fat or horrible. He would probably tell me about the nice things he sees in me.

Therapist: I'd like you to move over to your grandfather's chair and, as best as you can, try and be his kind voice. [*Client changes seats*]. Grandpa Tony, Susie has had a really tough few days. She feels really hurt by what her mother has said about her appearance. What would you like to tell her?

Lastly, chairwork role-plays can help the client embody the therapist's perspective and so begin internalising the Healthy Adult mode. As well as allowing clients to respond to their distress from the supportive vantage point of the therapist, this method can also provide an indirect and less threatening method of empathic confrontation. This is particularly helpful when working with individuals with EDs, who are often highly sensitive to rejection.

Limited re-parenting through chairwork role-play:

Client: I tried to introduce the meal plan but it was a disaster. I managed to follow it for one day and then I started binge-eating again. I'm such a waste of space.

Therapist: Do you think that I think you're waste of space?

Client: I don't know ... Probably not.

Therapist: If you were me right now, how would you see what's happened?

Client: I guess you'd think setbacks aren't unusual. You wouldn't think I was a complete failure.

Therapist: Can you come over here and sit beside me? [*Client moves seats*]. So, over there is someone who is trying their best to do something scary [*Gesturing to the empty chair*], but she's finding it really hard to do. She's working hard but, like every other human being, this scary new thing gets difficult at times. Now, as my co-therapist, would you say that individual is a waste of space for having that experience?

Client: No.

Therapist: Well, that's the way she feels right now. What would you want to say to her?

Client: I'd tell her it's great she's trying so hard, even though it scares her. That takes a lot of courage.

Therapist: Do you think she's a failure?

Client: No.

Therapist: How come?

Client: Everyone finds things hard the first time they do it, especially if it makes them feel anxious.

Therapist: Can you tell her that?

Client: You're not a failure.

Therapist: You're right, Susie. She's not a failure. You are not a failure.

Empathic confrontation through chairwork:

Client: I just couldn't cut back on my exercise this week. The urge was too strong. You must be so fed up of talking about my exercise routine over and over again.

Therapist: I'm not fed up, Susie. I can understand why exercising less is so difficult. You've been exercising like this for a long time, right? Whether you exercise or not doesn't change the care I have for you. At the same time, I'm concerned. I feel both those things right now - I care about you and I'm concerned. Does that make sense? [*Client nods*]. Have you ever felt care and concern for someone, at the same time?

Client: I felt that way when my mum was giving up smoking. I understood why she found it hard to stop smoking because I found it hard too, but I didn't want her to damage her lungs either.

Therapist: Would you mind moving over to this chair beside me, Susie? [*Client moves seats*]. I'd like you to step into my shoes for a moment, as if you are the therapist right now. How can you show the individual over there that you feel both care and concern for her? What would you say?

Client: I'd tell her that it's understandable that exercising less was difficult because it's a hard habit to break, but it's also really important that she cuts it down.

Therapist [*Gesturing to the empty chair*]: Can you tell her why that's important and why you care about that?

Client: It's important because the more exercise you do, the worse the eating disorder gets, and I don't want you to suffer like that...

Special considerations in Schema Therapy for eating disorders

The internal eating disorder 'voice'

Many individuals with EDs make reference to an internal eating disorder 'voice' (EDV) which has been linked to multiple aspects of eating psychopathology (Pugh and Waller, 2017). Albeit a

controversial concept (Pugh, 2016), working with the EDV can provide therapists with a welcome opportunity to stand shoulder-to-shoulder with clients against an aspect of their illness. Suggestions for working with the EDV in ST-ED include the following:

- Clinicians must establish which mode(s) are represented by the EDV. This can be achieved using diagnostic chairwork techniques, which enable schema therapists to identify the form, functions, and (most importantly) schema modes which are encapsulated by the EDV.
- Illuminating questions to pose during diagnostic interviews with the EDV may include its developmental origins ('Where do you come from?'), intent ('What is your role in this individual's life?') and motives ('What are your fears about not performing this role?').
- Research has linked the EDV to childhood trauma (Pugh and Waller, 2018). As such, dialogues with the EDV can provide an inroad to imagery rescripting later in therapy.

Therapist: So, anorexia, what is your role in Susie's life?

Client: My job is to make sure Susie doesn't eat too much and stays below her calorie limit. I push her to exercise as hard as she can, every day. If she doesn't do that, well, then I tell her off. She needs to stick to the rules and do exactly as I say [*EDV as demanding parent mode*].

Therapist: What do you think would happen if you weren't doing this in Susie's life?

Client: She'd become lazy and out of control. If she wants to eat, she needs to earn it.

Client and therapist go on to explore the origins of the EDV and its manifestations.

Therapist: Thank you for taking the time to speak with me, anorexia. It has been very helpful getting to know you better. Susie, can you come back to your chair?

Therapist and client de-brief following the dialogue.

Therapist: I wonder, did the voice remind you of any of the modes we have talked about lately?

Client: Well, it reminded me a bit of the demanding mode you mentioned.

Therapist: That's what I thought too. It really does sound like your demanding mode plays a big role in your exercise and calorie counting. Does it remind you of anyone you've known?

Client: Now that you say that, it kind of reminds me of my dad. I remember he would always tell us not to overeat at dinner...

Attachment to punitive or demanding modes

Due to their egosyntonicity, some individuals value the more punitive or demanding aspects of their ED. For example, self-attacks by the punitive mode can be seen as functional in terms of motivating corrective action (e.g. purging) or facilitating 'restorative justice' (e.g. punishment through restriction). Consequently, therapists' attempts to 'fight' parent modes might be experienced as threatening or destabilising. Strategies for managing, and eventually overcoming, the defence of parent modes include:

- Seeking the client's permission to confront parent modes during chairwork and soliciting feedback afterwards.
- Focusing more on the client's affective reactions to parent modes to motivate boundary-setting and help elicit their own healthy adult responses.
- Exploring how the client might respond if a loved one experienced similar demands or attacks.

Client: *[As the punitive parent]* You're a lazy slob. You're a total pig for binge-eating.

[Client moves back to vulnerable child chair].

Therapist: How do you feel hearing that?

Client: It's true. I am a lazy slob. I need to control myself better.

Therapist: I see, so up here *[points to head]* you really agree with what it says. What happens inside when your punitive parent speaks to you like that, Susie? How does it make you feel?

Client: I feel really beaten down. I just want to hide away.

Therapist: You feel really hurt?

Client: [*Nods*].

Therapist: It must be really hard getting through the day when you are constantly put down like that.

Client: It is. [*Client becomes tearful*]. Sometimes I just want to give up. I get so depressed.

Therapist: So, there you are, an imperfect human being doing their best, and then there's this other part constantly berating you. What do you need from that side?

Client: I need it to give me a break sometimes.

Therapist: I think you're right. You do deserve a break. It isn't fair the way it speaks to you. I'd like your permission to say something to your punitive parent mode along those lines. Is that ok??

Over-regulation of emotion (emotional suppression and inhibition)

Individuals with EDs tend to inhibit their emotional reactions. Of all of the emotions, anger can be especially difficult for individuals with EDs to acknowledge, validate and express. Furthermore, anger is often accompanied by feelings of self-disgust and guilt (i.e. activation of parent modes) (Fox and Harrison, 2008). This is can be obstructive in ST given that healthy anger can help facilitate schema modification (Young, 1990). Strategies for working with anger and anger suppression include:

- Using the client's nomenclature to refer to anger, which can feel less threatening (Therapist: "Can you tell your schema about how it *pisses you off*?").
- Initially encouraging safer, less intense expressions of anger during chairwork, e.g. asking the client to read 'no send' letters (in imagination) to individuals who inspire irritation.
- Bypassing coping modes which inhibit expressions of anger (e.g. the detached protector mode) and/or silencing modes which attack the client for expressing annoyance (e.g. parent modes).
- Role-playing individuals who express anger in healthy ways (Therapist: "Can you think of someone who expresses their anger in a helpful and assertive way? How do you imagine they would respond to a punitive mode like this? Can you show me?").

- Encouraging anger expression by using increasingly evocative language to describe the client's emotional experience (Therapist: "Can you respond to your punitive parent mode from your irritated / annoyed / angry / enraged side?").

Under-regulation of emotion (distress intolerance)

At the other end of the emotional regulation continuum, some clients with EDs struggle to tolerate emotional distress (Anestis et al., 2007). As a result, evocative interventions such as chairwork can generate considerable anxiety. Several adjustments can be made during chairwork to help manage these concerns and temper clients' levels of emotional arousal:

- Rather than embodying distressing modes, clients can at first be invited to stand behind the chair of the mode and speak from this perspective in the third-person (Therapist: "What is the punitive parent saying to Little Susie now?").
- A 'safe chair' can be included in chairwork, so that the client has a protective place to move to if they feel overwhelmed.
- Delaying the more evocative forms of chairwork (e.g. historical role-play) until a containing alliance has developed, and the client has greater resources for managing distress, is often important.

Other issues

- Individuals with EDs often feel self-conscious when engaging in chairwork. Enacting modes on behalf of the client (under their direction), or demonstrating the interactions between one's own schema modes through chairwork, can help normalise the dialogical process and build confidence in chair-techniques.

- Alexithymia (i.e. difficulties identifying and describing emotions) is common in EDs. Chairwork techniques such as the ‘emotional selves’ exercise (see Gilbert, 2009) and ‘physicalising’ affective states in the empty chair (Therapist: “What colour and shape would ‘sadness’ be?”) are useful ways to help clients concretise and get to know their emotions better.
- Therapists shouldn’t don’t give up if individuals initially refuse to engage in chairwork or discount it: patient persistence is often required with this client group.

Conclusion

Chairwork has stood the test of time and continues to inspire therapists from diverse therapeutic backgrounds. Within schema therapy, chair-based techniques provide a powerful medium for combining cognitive and affective elements to help bring about last schematic change. Although evidence for effectiveness remains limited in the EDs, preliminary findings and clinical experience suggests that these techniques represent a promising method for working with the challenges that often arise with this population. It is hoped that through further research and continued clinical application, chairwork will continue to be recognised as an effective, and perhaps vital, tool in schema therapy for ED and other client groups.

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Table 1: Process-skills in chairwork

| Skill | Example |
|--------------------------------|--|
| Maintaining boundaries | <p>Keeping voices clear C: I might be ok as a person, but I still look like a slob. T: It sounds like your punitive parent mode is really coming out now. Let's put that critical part of you in the empty chair.</p> <p>Personification C: I get so tired of these constant thoughts to exercise more and more. T: Let's speak to your demanding parent mode then. If that mode were sat in the empty chair, how do would it look?</p> <p>Embodiment C: My body looks so horrible and disgusting. T: That sounds like your punitive mode. Can you change seats and speak as that part of yourself for a moment?</p> <p>Directing attention C: <i>(to the punitive parent)</i> Leave me alone! <i>(turning to the therapist)</i> This parent mode really isn't helpful, is it? T: <i>(re-directing attention)</i>. Try saying that to your parent mode. "You're not helping me".</p> |
| Facilitating expression | <p>Elaboration C: <i>(to the detached protector mode)</i> It's not helpful to always feel numb. I need to feel my emotions sometimes. T: Tell the detached protector more about why you need to feel sometimes.</p> <p>Specificity C: <i>(to the demand parent mode)</i> You stop me living my life. T: Tell that side about the specific ways it stops you living a happy life.</p> |
| Heightening affect | <p>Repetition C: <i>(to the vulnerable child)</i> There's nothing wrong with you. T: Tell Little Susie that once more, "there is nothing wrong with you".</p> <p>Tone C: <i>(to the punitive parent)</i> Stop putting me down. T: Say that again, but louder this time.</p> <p>Posture C: <i>(to the demanding parent)</i> I'm allowed to eat what I like. T: Try standing up as you say that.</p> <p>Exploring non-verbal communication T: When you speak to the punitive mode you seem so composed, but I also notice you are clenching your fists. C: I guess I feel quite angry right now. T: I see, so there's actually some anger there. Can you put your anger into words?</p> <p>Offering statements</p> |

| | |
|------------------------------|--|
| | <p>C: <i>(to the vulnerable child)</i> Being abused wasn't your fault.</p> <p>T: Yes, no child deserves to be treated like that. You are a good little girl. Can you try saying that to Little Susie?</p> |
| Responsibility taking | <p>Owning perspective</p> <p>T: <i>(to the self-soothing mode)</i>. You just make things worse when you encourage me to binge.</p> <p>C: Tell that side how that feels to you. What's <i>your</i> experience?</p> <p>T: I just feel sadder when I binge. It's not helpful.</p> <p>Existential language</p> <p>C: <i>(to the punitive parent mode)</i>. If I want to eat, I'm going to eat! That's up to me, not you!</p> <p>T: Try saying, "From now, I'm going to decide to eat when I like".</p> |

