

# Motivational chairwork: An experiential approach to resolving ambivalence

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## Abstract

Ambivalence about change is a common obstacle in psychotherapy. Motivational interviewing (MI) is a popular person-centred approach which aims to elicit and reinforce intrinsic motivation to change, but also has been associated with theoretical and empirical limitations. Drawing upon theories of cognition and emotion, this paper provides an integrative framework for understanding ambivalence and its resolution in psychotherapy. Informed by these theories, the transtherapeutic concept of 'motivational chairwork' is introduced. Three motivation-focused chairwork techniques (empty-chair, two-chair, and role-play formats) are described using the example of ambivalence occurring within the context of anorexia nervosa. Future directions for research and clinical implications are discussed.

**Keywords:** Ambivalence; chairwork; eating disorders; empty-chair; motivation; resistance; two-chair

## Abstrait

*L'ambivalence à propos du changement est un obstacle courant en psychothérapie. L'entrevue motivationnelle (MI) est une approche populaire centrée sur la personne qui vise à susciter et à renforcer la motivation intrinsèque au changement, mais qui a également été associée à des limitations théoriques et empiriques. S'appuyant sur les théories de la cognition et de l'émotion, cet article fournit un cadre intégratif pour comprendre l'ambivalence et sa résolution en psychothérapie. Fondé sur ces théories, le concept transtherapeutique de «chaire de motivation» est introduit. Trois techniques de chaire axées sur la motivation (formats de chaise vide, de deux chaises et de jeux de rôle) sont décrites à l'aide de l'exemple de l'ambivalence se produisant dans le contexte de l'anorexie mentale. Les orientations futures pour la recherche et les implications cliniques sont discutées.*

**Mots clés:** Ambivalence; travail sur chaise; troubles de l'alimentation; chaise vide; motivation; la résistance; deux chaises

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## INTRODUCTION

Ambivalence about change is a common human experience and one which can have serious implications within the context of psychopathology. Motivational interviewing (MI) is a popular therapeutic approach for resolving indecision and encouraging behavioural change (Miller & Rollnick, 2002). A collaborative, person-centred and directive intervention, MI aims to evoke and

reinforce intrinsic motivation to change. This is achieved using a number of therapeutic skills including exploratory questioning, affirmation and reflective listening, as well as therapy-specific principals such as "rolling with resistance" to change. Crucial to the approach, MI aims to elicit change-supportive statements ("change talk") by highlighting the discrepancy between current behaviour and underlying values. The centrality of developing discrepancy and change-talk to MI

has been supported by research which has linked both variables to better treatment outcomes (Amrhein et al., 2003; Apodaca & Longabaugh, 2009). Theoretically, MI has been informed by insights from experimental psychology. These include the observation that people become committed to positions they hear themselves defined (self-perception theory; Bem, 1967) and, relatedly, that discrepancies between one's actions and broader values can generate cognitive and behavioural readjustments (cognitive dissonance; Festinger, 1957).

A large body of research suggests that MI is effective in reducing a number of high-risk behaviours including alcohol consumption, drug addiction, and gambling (Lundahl & Burke, 2009), as well as promoting positive health-related behaviours (Martins & McNeil, 2009). Outcome studies also indicate that positive responses to MI are often maintained post-treatment and that this is not influenced by problem severity (Lundahl & Burke, 2009). In addition, pre-treatment interventions based upon MI (for example, motivation enhancement therapy) appear capable of improving engagement and retention in treatments such as cognitive behavioural therapy (CBT; Westra, Arkowitz, & Dozois, 2009) and, when compared against such therapies, often produce equivalent outcomes in shorter periods of time (Lundahl & Burke, 2010).

Adapted forms of motivational interviewing (AMIs) have proved particularly popular in the treatment of eating disorders, most notably anorexia nervosa (AN), where a reluctance to change is common (Treasure & Schmidt, 2008). AN is regarded as being amongst the most challenging disorders to treat, due in part to the ambivalent attitudes which often characterise the illness (Vitousek, Watson & Wilson, 1998). By encouraging a shoulder-to-shoulder approach to treatment, MI enables the therapist and client to work in collaboration, rather than in opposition, thereby circumventing common therapist traps such as enforcing, coercing and arguing for change which may, unintentionally, compound resistance (Treasure & Ward, 1997). It is unsurprising, therefore, that many evidence-based therapies for AN incorporate some form of motivational-focused intervention (either as a treatment module or throughout the course of therapy) to help overcome ambivalence and bolster commitment to change (Fairburn et al., 2009).

Despite its robust evidence-base, MI is not without limitations. Empirically, meta-analytic studies indicate that the effect sizes of MI are generally small (Lundahl & Burke, 2009) and outcomes are inconsistent across research trials (Hettema, Steel,

& Miller, 2005). In addition, comparison studies suggest MI has a significant, albeit modest, advantage relative to weak treatments such as waitlist controls (e.g. Lundahl et al., 2010) and no advantage compared to active therapies such as CBT (e.g. Knowles, Anokhina & Serpell, 2013). Theoretically, associations between treatment outcomes and underlying psychological processes in MI remain unclear. Whilst connections with psychosocial models such as cognitive dissonance have been proposed, these links have been largely inferred following the development of MI (Miller & Rollnick, 2009). Whether MI neglects the affective elements of ambivalent states has also been argued (Pugh & Evans, 2016).

Unfortunately, empirical support for the use of MI in eating disorders is particularly lacking. A converging body of research indicates that AMIs are relatively ineffective in ameliorating disordered symptoms (the exception being binge-eating) and perform no better than bonafide treatments such as CBT in enhancing motivation (Knowles et al., 2013; Waller, 2012). Why motivation-focused interventions are largely ineffectual in promoting change in AN remains uncertain, although a number of disorder-specific factors are implicated. These may include the egosyntonic nature anorexic symptoms, entrenched patterns of eating behaviour, pro-illness beliefs, starvation-related cognitive impairments, and the reinforcing biopsychosocial features of starvation (Pugh & Evans, 2016; Pugh & Salter, 2017; Vitousek et al., 1998; Waller, 2012). New directions for resolving ambivalence in disorders such as AN, which acknowledge the core features of eating pathology, are needed.

## RESOLVING AMBIVALENCE: THEORETICAL CONSIDERATIONS

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In light of the theoretical and empirical shortcomings associated with MI, and given the disappointing treatment outcomes for disorders such as AN (Watson & Bulik, 2013), novel approaches for understanding and resolving ambivalence in psychotherapy seem justified. The following section reviews contemporary theories of cognition and emotion which, together, provide an integrative framework for understanding ambivalence and so may help inform new interventions for enhancing motivation to change.

### Interacting cognitive subsystems

The model of Interacting Cognitive Subsystems (ICS; Teasdale

& Barnard, 1993) is a complex theory of information processing allied with cognitive and behavioural therapies (CBT). The ICS proposes two distinct levels of knowledge: a propositional code, which is concerned with specific, verifiable and language correspondent meanings (“head-level” or analytic information processing) and an implication code, which is concerned with more implicit, intuitive and emotion-correspondent meanings (“gut-level” or affective information processing). Whilst propositional knowledge has no link with emotion or sensory information such as bodily feedback, the implicational code shares a direct relationship with affective, physical and kinaesthetic inputs. Disconnects may occur between the propositional and implicational codes resulting in a dissociation between what is known intellectually (“my behaviour is bad for my health”) and what is known emotionally (“my behaviour feels good”) - a phenomenon commonly referred to as the “head-heart lag” (Stott, 2007).

ICS has implications for motivational interventions. It has been argued that most interventions utilised in MI are principally discursive (e.g. reviewing the relative costs and benefits of change) and so risk achieving only limited propositional (cognitive) change. Deeper and more enduring implicational (emotional) change may be neglected, therefore (Pugh & Evans, 2016). This rational-affective disconnect in the context of ambivalence may provide some explanation as to the conflictual change statements observed in disorders such as AN (“I want to recover and stay as I am”), as well as clients’ “change manifestos” which do not translate into behaviour adjustments (Waller, 2012). In order to modify implicational knowledge and thereby increase the likelihood of behavioural change, ICS would suggest that experiential and emotionally evocative techniques, which impact all schematic levels through multisensory inputs (sights, sounds and movement), are likely to be most effective (Pugh, 2017a).

### Retrieval competition

Also associated with cognitive approaches to psychotherapy, the theory of retrieval competition (Brewin, 2006) postulates that positive and negative mental representations compete for retrieval from longer-term memory. In emotional disorders, negative representations (e.g. the belief “I am fundamentally unacceptable”) are theorised to be highly accessible whilst more functional competitor representations (e.g. the belief “I am acceptable”) are not. Endowed with this “retrieval advantage”, maladaptive representations are likely to guide subsequent

thinking and behaviour. The aim of psychotherapy, therefore, is to construct, strengthen and enhance the relative accessibility of alternative positive mental representations so that they may be more easily retrieved and guide adaptive behavioural responses (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015).

The theory of retrieval competition would imply that resolving ambivalence may partly rely on the construction of positive mental representations about behaviour change. Crucially, these representations must be sufficiently distinctive, memorable and attention-grabbing to out-compete maladaptive representations which maintain the status quo. If achieved, positive representations of recovery should then be used to guide cognitive appraisals and decision-making in situations related to the object/subject of ambivalence.

### Adaptive emotion

Recent models of emotion have emphasised the functional dimensions of affect (Frijda, 1986; Nesse & Ellsworth, 2009). Evolutionary psychology, for example, proposes that emotional states are rooted in the advantages they provided our ancestors in terms of survival, natural selection, and goal attainment (Cosmides & Tooby, 2000; Gilbert, 2009). To illustrate, the subjective experience of anxiety may be valuable in conveying important information to the self and others (“this situation is potentially dangerous”), as well as motivating protective reorientations in behaviour (vigilance for threats and preparedness to escape). This is not to say that all types of affect are functional all of the time: emotional reactions which are overwhelming or inappropriate to the situation may be maladaptive, particularly in the modern environment. However, primary emotions such as anger, sadness and anxiety may function as adaptive organising processes which stimulate action towards important values and goals which fulfil core needs (Thoma & Greenberg, 2015).

Little attention has been paid to the importance of affect in resolving ambivalence. This is surprising given the centrality of emotion in the experience of cognitive dissonance (Elliot & Devine, 1994) - what has been described as, “an unpleasant, drive-like state” (Draycott & Dabbs, 1998, pp.342). How might working with affect be productive in the context of ambivalence? Firstly, bringing attention to core emotional reactions regarding the ‘status quo’ conveys important information to the self and may help encourage behavioural change. Anger, for example, can help motivate healthy boundary setting around destructive behaviours, whilst anxiety may highlight a need to establish

safety through the reduction of high-risk repertoires. Secondly, if emotion is a core feature of cognitive dissonance, then focusing on the emotionally discomfiting aspects of this experience might help deepen discrepancy and so generate behavioural adjustments.

### Theoretical implications

Combining the aforementioned theories of cognition and emotion, we hypothesise that motivational interventions are likely to prove particularly effective if they fulfil the following criteria:

- They must be multisensory (incorporating imagery, sound and movement).
- They must be memorable and readily recalled.
- They must be emotive.

### CHAIRWORK

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Chairwork – a transtherapeutic collection of action-based, experiential techniques - has experienced renewed interest within psychotherapy. First developed within group psychodrama (Moreno & Moreno, 1969), chairwork has since been adopted into a number of popular therapies including emotion-focused therapy (Greenberg, 2015), CBT (Pugh, 2017a), schema therapy (Young, Klosko, & Weishaar, 2006), compassion-focused therapy (Gilbert, 2010) and integrative approaches (Goldfried, 2006, 2013). Research indicates that chairwork techniques can be successfully applied in the treatment of a range of emotional difficulties including depression and childhood trauma, as well as psychopathological processes such as self-criticism and rumination (Greenberg & Watson, 1998; Paivio & Nieuwenhuis, 2001; Shahar et al., 2012). More specific to the topic of this paper, preliminary studies also indicate that chairwork techniques are an effective method for resolving indecision (Greenberg & Dompierre, 1981) and outperform cognitive interventions such as problem-solving in addressing ambivalence (Clarke & Greenberg, 1986).

Three core forms of chairwork are utilised across psychotherapies (Kellogg, 2015; Pugh, 2017a). Empty-chair techniques such as “unfinished business” (Paivio & Greenberg, 1995) involve the client dialoguing with an imagined “other” (past, present or symbolic) placed in an empty seat. Multi-chair techniques require the client to speak from two or more seats, each representing a different perspective or position (for example, the

evidence supporting and disconfirming a negative self-belief). Lastly, chairwork role-plays involve the client and/or therapist enacting particular person(a)s and may be either interpersonally or intrapersonally focused. Interpersonal chairwork role-plays involve enacting individuals from the client’s external world; for example, the therapist may enact an authority figure (e.g. the client’s manager) so that assertiveness skills can be rehearsed. Intrapersonal chairwork role-plays require the therapist or client to enact persons from the client’s internal world; for example, the client may speak from the position of their “inner critic” and so be interviewed by the therapist in regards to its functions, intentions and needs.

Whilst the forms and functions of chairwork vary across psychotherapies, these interventions are unified by a number of transtheoretical principles. These ‘common ingredients’ are now outlined with reference to motivational forms of chairwork.

### Chairwork principles

#### *Self-multiplicity*

Self-multiplicity<sup>1</sup> refers to the philosophical position that the self can be conceptualised as being composed of multiple, interacting parts or perspectives. These parts of the self have been referred to in various ways including ‘modes’, ‘selves’, ‘self-states’, and ‘I-positions’ (the term of reference adopted henceforth). I-positions also are subject to power dynamics, insofar as some parts of the self may come to suppress, dominate, or support other parts (Hermans, 2004). Within the context of psychopathology, emotional distress may be conceptualised as reflecting a limited number of maladaptive I-positions (monological internal dialogues), the dominance of distressing I-positions (tyrannical internal dialogues), or a rigidity of I-positions (inflexible internal dialogues; (Dimaggio, Salvatore, & Catania, 2004). As a therapeutic technique, chairwork assumes a multiplicity of mind in that different I-positions or perspectives can be represented by multiple chairs. In this way, chairs not only help disentangle and concretise the I-positions implicated in clients’ presenting difficulties (including states of ambivalence), but their separation creates a space wherein therapeutic interactions between these self-parts can take place.

When in a state of ambivalence, clients tend to describe their internal worlds as highly polarised insofar parts of the self are simultaneously pulled both towards and away from change (Kellogg, 2015). When these conflicting I-positions become fixed or fail to reach a point of resolution, “stuckness” and

maintenance of the status quo ensues. What I-positions are likely to be implicated in ambivalence or a contemplative stage of change? Typically, chairwork with ambivalence involves working the part(s) of the client that “want to change” versus those the part(s) which “do not want to change”. Alternatively, chairwork may involve addressing the part(s) of the client which “wish for change” versus those which are “scared of change” (i.e. a conflict between the client’s ‘rational’ versus ‘emotional’ I-positions).

### ***Embodiment and personification***

Once relevant I-positions have been identified, they must be given a capacity to convey and receive information in order to reach a point of resolution or modification. In the context of chairwork, this is achieved through either embodiment or personification. Embodiment involves the client changing seats and ‘becoming’ or speaking ‘as if they were that I-position (Therapist: “Change seats and speak from the side of you that does not want to change”). Personification, on the other hand, invites the client to imagine the I-position as something ‘person-like’ in the empty chair and (without changing seats) relaying what the I-position is communicating in the second or third person (Therapist: “What is the ‘inner critic’ saying from the chair over there?”).

In order to ensure personifications are as representational as possible, sensory characteristics of the I-position are explored as a preliminary step in chairwork. For example, the client may be asked to consider:

- What would that side of you look like? (E.g. male, female, object, or symbol)
- What would it be wearing?
- What expression would it hold?
- What tone of voice would it use?
- How do you feel in its presence?

As Rowan (2010) has argued, quite literally anything can be embodied or personified in chairwork. Clients may be invited to embody parts of themselves (e.g. the I-positions that do and do not want to change), others (e.g. internalised individuals who support or do not support change), emotions (e.g. hopes and fears related to change), objects (e.g. the tangible rewards and losses related to change), and symbols (e.g. one’s goals, values and aspirations). Accordingly, each I-position implicated in the state of ambivalence can be invited to “assume a voice and convey a message” through the medium of chairwork (Morioka, 2012, pp.399).

### ***Dialogue***

In order to address conflicts between I-positions, they must be given the ability to speak to one another so that resolution can occur. In the case of the polarised I-positions which characterise ambivalence, each side should be encouraged to “advocate their unique wants, concerns, fears and aspirations in a back-and-forth communication... designed to bring the conflict to a conclusion and enable action to ensue (Nir, 2012, pp.284)”. Given that I-positions are capable of listening as well as verbalising, these dialogical exchanges allow self-parts to be transformed, reorganised, empowered and better integrated.

Chairwork is a fundamentally dialogical process insofar as each I-position is encouraged to speak as expressively as possible. This may be with the intention of better understanding an I-position (Therapist: “From this side, state the reasons for not changing”) or facilitating exchanges between I-positions (Therapist: “Tell the critical side of you about the damage it has caused”). Like interpersonal communication, chairwork dialogues also rely on a process of ‘turn taking’: for example, the reasons to change might first be outlined in chair one, followed the reasons to not change outlined from in chair two, followed by counter-responses in chair one again, and so on. Whether dialogues between I-positions aim to achieve integration (e.g. resolving ambivalence about change) or adjust the relative power of particular I-positions (e.g. reducing fears about change) will depend upon the goals of chairwork and the orientation of therapy.

### ***Chairwork processes***

When facilitating chairwork dialogues, therapists draw up number of process-related skills derived from gestalt, humanistic, and cognitive-behavioural schools (Perls, 1973; Greenberg, 1979; Kellogg, 2015; Pugh, 2017a). Broadly speaking, these skills relate to a) maintaining I-position boundaries, b) facilitating the expression of I-positions, c) heightening affect, and d) encouraging responsibility taking. Whilst an exploration of these “micro-skills” of chairwork is beyond the scope of this paper, key process methods are outlined in Table 1.

## **MOTIVATION CHAIRWORK: RESOLUTION THROUGH EXPERIENCE**

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Motivational chairwork (MC) refers to an assembly of experiential interventions which aim to resolve ambivalence and encourage positive decision-making. As with other chairwork methods, MC

**Table 1: Process methods in chairwork**

<b>Skill</b>	<b>Example</b>		
<b>Maintaining I-position boundaries</b>	<b>Separating</b> T: I need to recover but I'm scared. C: So in this chair is the side that wants to change and in this chair is the side that is scared of change		
	<b>Personification</b> T: I feel like I need anorexia in my life. C: If anorexia were sat in that chair, how do you imagine he or she would look?		
	<b>Movement</b> C (in the 'benefits of change' chair): I want do to recover but a lot of the time anorexia feels so safe. T: It sounds like the 'not recovering' side is speaking. Change seats.		
	<b>Directing attention</b> C: (in the 'pro-recovery' chair): I'm fed up of you, anorexia! (To therapist) I need to change how I eat, don't I? T: (re-directing client's attention). Try saying that to anorexia.		
	<b>Facilitating expression</b>	<b>Elaboration</b> C: I want to recover because I want my freedom back. T: Say more about the freedoms you want back.	
		<b>Specificity</b> C: From now on things will be different with food. T: Tell that side how you are going to do things differently with food.	
		<b>Symbolising non-verbal communication</b> T: I notice your voice trembling. Try to put that into words. C: I feel so weak and shaky.	
		<b>Heightening affect</b>	<b>Repetition</b> C: I want my happiness back. T: That's important, say that again.
			<b>Tonality</b> C: I don't like the way you treat me, anorexia. T: Say that again, but louder this time.
	<b>Offering statements</b> T: Since I've been unwell I don't see my friends anymore. C: Try saying, "I feel so lonely living with anorexia".		
<b>Responsibility taking</b>	<b>Owning one's perspective</b> T: You're too controlling of me, anorexia! C: Tell that side how that feels to you. What's your experience? T: I feel trapped and suffocated with you, anorexia.		
	<b>Existential language</b> C: I think it's time to change. T: Try saying, "I am making the decision to change".		

is rooted in the assumptions of self-multiplicity, embodiment, personification, and the benefits of intrapersonal dialogue.

MC shares a significant degree of overlap with the spirit of MI. MC, like MI, aims to resolve ambivalence by supporting client self-efficacy, expressing empathy, rolling with resistance and, crucially, developing discrepancy by selectively eliciting and reinforcing “change-talk” elicited during chairwork dialogues. Basic therapist skills used to achieve these goals in MI (open-ended questioning, reflective listening, affirming and summarising) are also utilised in MC. Accordingly, MC seems compatible with MI and may provide a valuable augmentation to the approach, as well other therapies which incorporate motivation-focused interventions such as CBT (Fairburn et al., 2009; Waller et al., 2007).

Important differences between MC and MI do exist, however. Firstly, rather than being a talk-focused intervention, MC is a fundamentally experiential approach insofar as immersive in-session exercises are used to help resolve ambivalence and reinforce motivation to change. Secondly, MC is an affect-focused intervention (e.g. eliciting and deepening the emotions which encourage change) as well as being a cognition-focused intervention (e.g. eliciting and reinforcing the client’s reasons to change). The idea that evocative and experiential chair-based interventions are well suited to resolving ambivalence has been informed by theories of emotion and information processing outlined earlier, as well as existing outcome studies pertaining to efficacy of chairwork (Clarke & Greenberg, 1986; Greenberg & Dompierre, 1981). The centrality of affect when working with ambivalence is also based in part on the observation that disorders characterised by high levels of ambivalence (e.g. AN) are often associated with impoverished emotional awareness, expression and processing (Harrison, Sullivan, Tchanturia, & Treasure, 2009; Lavender et al., 2015).

Distinctions can also be made between MC and other forms of chairwork. Unlike non-directive chair-based techniques which aim to explore ambivalence (e.g. Engle & Arkowitz, 2008), MC is purposely directive insofar as it intends to guide individuals towards particular goals and intentions which are consistent with the amelioration of emotional distress and adaptive functioning. Like MI, this is achieved by selectively eliciting and reinforcing cognitive indicators of decision resolution (“change talk”) and, more unique to MC, selectively eliciting and reinforcing affective markers of decision resolution (“change emotions”). In the context of eating pathology, examples of change emotions may include deepening the anxiety felt about continuing disordered

food-related behaviours, bringing to life the excitement about the prospect of recovery, and elaborating the frustration at the status quo.

### Therapist stance in motivational chairwork

Depending upon therapeutic orientation and the focus of chairwork, therapists tend to adopt either supportive, facilitative or directive roles during dialogues (Kellogg, 2015). In common with MI (Miller & Rollnick, 2002), and particularly when working with ambivalence in the context of psychopathology, MC advocates an empathic yet directive therapist stance. Therapists should play an active role in guiding chairwork dialogues towards outcomes which are likely to generate healthy behavioural adjustments by selectively deepening and reinforcing markers of positive decisional resolution. It goes without saying that determining when and how to use such methods requires judgment and experience, lest they unintentionally elicit greater resistance or “sustain-talk” (Arkowitz & Miller, 2008). Generally speaking, we find a tentative rather than forceful stance is best adopted when guiding chairwork towards therapeutic outcomes.

## MOTIVATIONAL CHAIRWORK INTERVENTIONS

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The following section describes three MC interventions which utilise the basic formats of chairwork (two-chair, empty-chair and role-play formats) which we feel can be readily integrated into treatments such as MI. Readers will notice that each technique is preceded by written homework exercises (Treasure & Schmidt, 2008). Whilst optional, preparatory homework can be helpful in MC for three reasons. Firstly, homework encourages reflection prior to chairwork and so helps prime relevant beliefs and cognitions prior to the dialogue. Secondly, writing is naturally evocative and so can be valuable preparation for emotive interventions like chairwork. Thirdly, written information provides a useful point of reference if chairwork dialogues begin to ‘dry up’ or if the client is struggling to fully express themselves.

Each chairwork intervention has been illustrated utilising fictitious therapy transcripts which draw from fictitious eating disorder cases (appendix one - three). It is important to note that these techniques have not yet been subjected to empirical testing.

### Two-chair technique: Two-chair decisional balance technique

The two-chair decisional balance technique is similar to a “dramatised” pros and cons list. Clients are asked personify the

parts of their self which do and not want to change in separate chairs and to speak as expressively as possible from each position. As the dialogue proceeds, a point of consensus and resolution is achieved. This two-chair intervention typically proceeds as follows:

1. The client is asked to complete a list of the advantages and disadvantages of living with their eating disorder which is reviewed.
2. The client is invited to conceptualise the pros and cons of their eating disorder as “the part which wants to change” and “the part which wants to stay as I am”.
3. After assessing which side feels most powerful and taking the appropriate seat, the client is encouraged to express the reasons underlying the dominant I-position as fully as possible.
4. As counter-perspectives emerge, the client is asked to change seats and express the counter I-position as fully as possible.
5. The client moves back-and-forth between chairs until both sides have been fully expressed. He or she is then invited to stand and, from an observing / metacognitive position, explore their cognitive and affective reactions towards each I-position. Shifts in ambivalence are commonly observed at this point.
6. I-position chairs are then reconceptualised in more decisive terms, i.e. the side which will change and the side which will not change. The client is invited to sit in whichever chair feels most dominant (most often the “change” chair) and express the reasons for occupying this position as powerfully as possible.

Clients will usually end this intervention by selecting the chair representing ‘change’ and encouraging the client to speak from this chair will often generate powerful statements of commitment (‘change talk’). However, therapists should not be dismayed if the client selects the chair representing non-change. If clients speak from this position, important information regarding pro-illness beliefs or fears about change is captured. In such instances, the client can also be invited to experiment with speaking from the chair representing change to see what this position feels like.

Depending upon the outcome of the exercise, useful post-intervention homework assignments may include making a list of the reasons to recover, future-orientated letter writing exercises (see below) and/or developing a preliminary recovery action plan.

#### **Chair-based role-play technique: Chairwork with ‘future selves’**

Chairwork role-plays with ‘future selves’ involve the therapist engaging in a fictitious interview with two ‘versions’ of the client: their self in five years’ time as if their eating disorder had been maintained, and their self in five years’ time as if they were fully recovered. The technique proceeds as follows:

1. The client is asked to write two ‘letters from the future’ for homework (Treasure & Schmidt, 2008): firstly, a letter describing what life is like in five years’ time if they were still living with an eating disorder; secondly, a letter describing what life is like in five years’ time having recovered from the eating disorder. Both letters are read aloud to client in the following session.
2. The client is asked to imagine, in an empty chair, their “future and non-recovered self”. They are then asked to change seats and embody this self (chair one). The therapist then proceeds to explore with this self what life is like in various domains (e.g. their physical health, mental health, relationships, career, interests, and so on).
3. If appropriate, the client (as their non-recovered self) is asked to imagine their ambivalent self in an empty chair (chair two). The client is invited to share with their ambivalent self any words of wisdom or lessons learned (Therapist: “If you could go back and speak with your former self who was unsure about recovering, what would you want to tell him/her now?”).
4. The client is asked to stand and, from this observing position, explore their cognitive and affective reactions to their non-recovered self.
5. The client is asked to imagine, in an empty chair, their self in five years’ time who has recovered from the eating disorder. Again, they are then asked to change seats and embody this future-self (chair three). The therapist explores what a recovered life is like across multiple domains.
6. The client is asked to imagine their ambivalent self in an empty chair once more (chair two). The client (as their future-recovered self) is encouraged to share positive reasons for change and provide reassurance about the process of recovery.
7. The client is asked to stand and explore their cognitive and affective reactions to their non-recovered self.

Clients often report that both imagining and embodying their non-recovered self is an uncomfortable experience and one which

can be highly motivating. At the same time, embodying their recovered-self is often experienced as hopeful and exciting. The recovered self can also be a useful reference point as treatment progresses, especially when obstacles are encountered (Therapist: “I wonder what your recovered self would say about reaching a healthy BMI. Can you change seats and speak from that side of your self?”).

In terms of follow-up homework tasks, clients may find it helpful to experiment with writing both to and from their recovered self. For example, the client may write a letter to their recovered self describing their fears about change and respond to this with a second letter from the recovered self which provides reassurance, optimism and encouragement.

### **Empty-chair technique: Chairwork with anorexia as a ‘friend’ and a ‘foe’**

This chairwork technique involves the client engaging in an empty-chair dialogue with a personified version of their eating disorder or ‘eating disorder voice’ (Pugh, 2016). Drawing upon a motivational letter writing task (Serpell, Treasure, Teasdale, & Sullivan, 1999), the client is first asked to speak to their eating disorder as a “friend” and, later, as a “foe”. As the dialogue with the eating disorder progresses, the client is able to come into closer contact with the sadness, anxiety and anger associated with their illness and use this as a motivator for change:

1. The client is asked to write two exploratory letters to their eating disorder for homework: firstly, a letter addressing their eating disorder “as my friend” and secondly, a letter addressing their eating disorder “as my enemy” (Serpell et al., 1999).

2. In the following session, the client is asked to imagine that their eating disorder is held in an empty chair. Personified aspects of the eating disorder are discussed (e.g. gender, appearance and tone of voice) and the client’s emotional reaction to this presence explored.

3. The client is asked to read their ‘friend’ letter to the eating disorder and relay how the eating disorder responds to this. The client is encouraged to direct subsequent cognitive and emotional reactions to the empty chair.

4. The client is then asked to read their ‘foe’ letter to their eating disorder. Again, the eating disorder’s responses and the client’s cognitive-affective subsequent reactions to this are explored and expressed.

5. The client is invited to share any parting words or new commitments with the eating disorder before the dialogue is closed.

Working with a personified version of AN in this manner can highlight valuable directions for therapy. These may include two-chair exercises designed to resolve self-critical splits (Greenberg, 1979) or role-plays in which clients practice setting boundaries with their eating disorder. Alternatively, clients may consider writing a goodbye letter to their eating disorder outlining how the relationship with their eating disorder is going to change henceforth (see Schaefer, 2004).

## **DISCUSSION**

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MC represents a theoretically-informed, transtherapeutic and experiential group of interventions which aim to resolve ambivalence and encourage positive behavioural change. This article has outlined some of the ways in which these techniques might be integrated into treatments which enhance motivation to change such as MI and CBT. As an affect-focused group of interventions, we have found them to be especially useful in the treatment of disorders such as AN where emotional awareness and expression is inhibited, avoided or suppressed. Accordingly, they may prove valuable in disorders where traditional motivational interventions sometimes prove insufficient.

### **Future research**

Whilst preliminary research suggests that chairwork is an effective means to resolve ambivalence (Greenberg & Watson, 1998), the techniques presented in this have not yet been subjected to empirical testing. Such research is needed. Studies could seek to test the effectiveness of individual MC exercises or explore whether such interventions augment the effects of established approaches like MI. Whether the therapeutic effects of MC are maintained in the longer-term also requires investigation. Another option would be to explore the mechanisms of action underlying MC and so inform developments in these techniques. For example, Salter (2014) matched session content to treatment outcome in order to identify mediators of change in another experiential technique (imagery re-scripting). It would be interesting to apply the same methodology to MC. Conversation analysis (Sutherland, Perakyla, & Elliott, 2014) could also be used to examine therapist-client interactions during MC to identify key therapeutic processes. Lastly, this paper has proposed that motivation may be enhanced through the construction of salient and favourable representations of change, as well as the resolution of ambivalence. This represents a development in how therapists

build motivation to change. Given that other treatments which seek to enhance positive mental representations (rather than restructure maladaptive representations) have proven clinically effective (Korrelboom, de Jong, Huijbrechts & Daansen, 2009), this may be fruitful avenue for exploration. For example, could interventions such as MC and functional imagery training (Andrade et al., 2016) enhance the effects of MI through the construction of salient representations of goal attainment?

### Clinical implications

Chairwork has been described as both an art and a science (Kellogg, 2015). Whilst a basic outline of chair-based techniques has been provided, applying these interventions effectively requires practice and experience. Therapists are encouraged to develop competence using chair-based techniques before applying these interventions in clinical settings. It should also be noted that chairwork is not for every client. Highly avoidant individuals are likely to find, action-based techniques anxiety-provoking, whilst clients who struggle with affect regulation may find them emotionally demanding. Guidelines for using chairwork with such individuals has been provided elsewhere (Pos & Greenberg, 2012; Pos, 2014).

To help avoid difficulties, we find it helpful to provide clients with a brief outline about how MC works before getting underway. In line with MI, clients can then be asked if they would like to know more and, if willing, to give MC a try. This ensures a collaborative and informed decision is made beforehand. It should also be noted that MC is designed to help assist clients who are in a contemplative stage of change. For individuals who are ready to engage in committed action, phase two MI interventions (“strengthening commitment”) and behaviour-focused interventions such as CBT are likely to be most effective. Last of all, we would encourage the use of motivational interventions such as MC throughout the course of therapy rather than as a stand-alone treatment (Waller, 2013), and reiterate the importance of linking motivational work to active behavioural change.

In conclusion, MC may be a promising method for resolving ambivalence in psychotherapy. Theoretically informed and compatible with treatments such as MI and CBT, MC can be a helpful method for enhancing intrinsic motivation to change and encouraging positive behavioural adjustments. Research is now needed to test the ideas present in this paper and encourage further developments in the approach. ■

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**APPENDIX 1:**

**ILLUSTRATION OF THE TWO-CHAIR  
DECISIONAL BALANCE EXERCISE**

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T: Thanks for sharing your pro's and con's list, Sarah. It sounds like you have important reasons to both stay as you are and get better. What stands out to me is that there almost seems to be two parts to you - one side that wants to change your eating disorder and another which does not.

C: That sounds about right.

T: I wonder if you might be willing to do an experiment with me to help us understand these two sides of you better. Can I tell you more?

C: Ok.

T: What I'd like you to imagine is that in this chair [therapist draws up a new chair] we have the part of you that wants to change, whilst in this chair [therapist draws up a second chair, facing the first] we have the part of you that wants to stay as you are. I was hoping you could take seat in each of these chairs and speak from both sides so we can get to know each perspective better. Would you be willing to give it a go?

C: I can try.

T: Great. Which of these two sides feels strongest within you right now?

C: Definitely the side that doesn't want to change.

T: Ok, take a seat in that chair. [Sarah moves into the 'sustain' chair. The therapist draws up a third chair and sits beside client].

T: Why don't you start with the statement, "I don't want to change because...". You can use your pro's of anorexia list if you want to.

C: I don't want to change because anorexia makes me feel good. When I'm losing weight I feel powerful, like I'm achieving the impossible.

T: Anorexia makes me feel strong.

C: Totally! Getting your weight down is hard and not everyone can do it like I can. I'm good at it.

T: I see. If it fits with you perhaps trying saying, "anorexia makes me pretty special".

C: It does, anorexia makes me feel special and that feels good. Plus, as long as I'm losing weight then I've got a good excuse to not see my friends. I feel so self-conscious around them.

T: Anorexia justifies not seeing my friends.

C: [Silent, looking upset].

T: You look sad, Sarah.

C: But I miss my friends. I haven't seen them in so long now.

T: It sounds like the other side is speaking now. How about we change seats? [Sarah moves into the 'change' chair; therapist pulls up a fourth seat and sits beside her]. If it fits, try saying, "I want to change because I miss being with my friends".

C: I do.

T: Trying saying it aloud if you can, Sarah.

C: I miss my friends.

T: And that makes me feel really lonely, sometimes.

C: [Starts to cry] I do feel so lonely... And forgotten.

T: What else makes you sad about living with anorexia?

Sarah moves back-and-forth between the two chairs, verbalising the thoughts and feelings which support and oppose change, until both sides have been fully expressed.

T: Well done, Sarah. Let's stand for a moment. [Sarah and her therapist stand, looking down on the two chairs from an observing position]. What do you make of these two sides of your self?

C: [Pointing to the 'sustain' chair] That's the one I hear a lot, especially when it comes to eating. I don't think it's helping me much. [Pointing to the change chair] I feel better in that chair because I know I probably ought to put this illness behind me.

T: I wonder if you might be willing to repeat the exercise once more, but this time a little differently.

C: Ok.

T: I'd now like you to imagine that this chair is the side that definitely will not change [pointing to 'no change' chair], and this side is the side that will change [pointing to the 'change' chair]. Which side feels strongest right now?

C: That I will change.

T: Ok. Take a seat in that chair [Sarah sits in the 'change' chair]. Try starting with the statement, "I am going to change because...".

C: I'm going to change because I need to get better. I can't keep living like this...

T: Good.

C: Because it's tearing my family apart and it's tearing me apart. I want to start living my life.

T: That sounds important. Say that again.

C: I want to start living my life. I want to stop being a prisoner to this illness.

T: Again, but louder this time.

C: I want to stop being a prisoner! I want to live my life!...

**APPENDIX 2:**  
**ILLUSTRATION OF THE 'FUTURE SELVES' EXERCISE**

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The therapist has read Sarah's letters from the future aloud.

T: Thank you for sharing your letters, Sarah. I wonder if you might be willing to do an exercise to bring these letters to life a little bit?

C: What do you mean?

T: Well, what I was hoping we could do is imagine that, by chance, it's as if we have met again in five years' time and we're catching up. I would like to do this with two versions of your self. First of all, I'd like you to imagine that in this chair we have Sarah in five years' time who has kept anorexia in her life [therapist draws up a chair], whilst in this second chair we have Sarah in five years' time who made the decision to recover [therapist draws up a second chair, placed beside the first].

C: Ok.

T: What I would like to do is explore what life is like for these two versions of yourself. It's a bit like an imaginary interview. Would you be willing to give it a try?

C: Sure.

T: Why don't we start with Sarah in five years' time who has kept anorexia in her life. Before you change seats, just imagine that that version of yourself is sat in the chair over there. How do you imagine that version of your self looks?

C: She looks tired and thin. She's wearing so many layers of clothes because she's really cold.

T: How does she hold herself in the chair?

C: She's slouched and a little bit bent over, like it's too difficult to sit upright.

T: How do you imagine she might be feeling right now?

C: I don't think she feels much anymore. She's just empty inside. But beneath all that she feels pretty sad and lonely.

T: How do you feel towards her?

C: I feel sad for her. She's barely surviving and she's all alone.

T: Ok. What I'd like you to do is change seats and become that version of yourself as best as you can. All I'm going to do is just ask you some questions about what life is like for that version of Sarah. Does that sound ok?

C: I think so. [Sarah changes seats].

T: Hi Sarah, it's good to see you again. I think it was about five years ago that we were working together. How are you keeping?

C: [In a flat tone of voice]. Well, not so well really. I'm just plodding along.

T: I see. What are you up to these days?

C: Not very much. I'm working in a shop but that's just for a few days each week. It gets too tiring to work any longer than that. I don't really much do else.

T: I remember when we were working together you were studying at university. I think you were hoping to become a teacher. What happened with that?

C: I had to drop out of university not long after therapy. I couldn't keep up with the classes and all of the coursework. I just couldn't concentrate. So I ended up moving home and dad and getting a job nearby.

T: You sound sad when you say that. What makes you sad?

C: I wish I'd be able to keep going with my studies, that's all.

T: But that was too hard with anorexia?

Sarah and her therapist explore her life in other domains such as her relationships and physical health. Following the role-play, Sarah and her therapist stand up and explore the experience of "becoming" herself in five years' time with anorexia. Attention is paid to how it felt to enact this version of herself. Sarah is then invited to sit in the second future-self chair and enact her recovered self in five years' time. Again, Sarah's life in recovery is explored across various domains.

T: It's great to hear things are going so well for you, Sarah. But I also remember that there was a time when you really weren't sure if you did want to get better. [Therapist draws up an empty chair and places it in front of Sarah]. Imagine, for a moment, that we have Sarah from five years ago in this empty chair. This is the Sarah who felt unsure about recovery from anorexia. What would you want to say to her?

C: [To the therapist]. I'd say she needs to get better.

T: [Re-directing Sarah's attention]. Can you say that to her?

C: You need to do it, Sarah. You need to get better! It isn't easy but it will be worth it. There's so much for you to look forward to.

T: Tell her about what she has to forward to.

C: There's so much in front of you! You have so many adventures yet to come. You're going to travel to so many interesting places and meet so many new people.

T: If I remember correctly, Sarah back then was really scared about eating more. Can you tell her anything to help her feel reassured?

C: Eating more is scary but you are going to be ok. You can take it slow if you need to and the meal plan the team have put together for you will make sure you don't gain weight too quickly.

T: What else do you think she needs to know about getting better?...

**APPENDIX 3:**  
**ILLUSTRATION OF EMPTY-CHAIR**  
**EXERCISE WITH ANOREXIA**

T: Thank you for bringing in your letters, Sarah. Before we read through them I was wondering if you might consider doing an experiment with me. It may sound a little strange but you might find it interesting. Would you like to know what I was thinking of?

C: Ok.

T: I'd like you to imagine that anorexia were sat in this empty chair. [Therapist draws up a chair]. This way we can read your letters directly to your eating disorder and make the process feel a bit more real. Would you be willing to give it a try?

C: Hmm. I'm not sure I think of my eating disorder in that way.

T: That's ok. Perhaps see what happens?

C: I guess.

T: Great. Before we read your letters, let's visualise anorexia in that empty chair. If anorexia were sat there, what might he or she look like?

C: Well, I imagine anorexia would be a woman. A mean looking woman.

T: Ok. Try and imagine her in that chair. How does she look to you?

C: She's a thin woman in a black dress, buttoned up all the way up to her neck.

T: How old does she look to you?

C: She looks like she's in her 50s. She looks like a mean stepmother from a fairy-tale.

T: What expression does she have?

C: She's tight lipped and stern, like I've done something wrong. She looks disappointed.

T: Does she have a name?

C: Ana.

T: I see. How about you start by reading her your 'friend' letter?

C: Dear Ana, thank you for all the help you have given me over the years... [Sarah goes on to read her letter to Ana] ... Best wishes, Sarah.

T: Thanks for sharing your letter, Sarah. Now take a moment to look at Ana. How is she reacting?

C: She looks smug. She's pleased I'm so grateful to her.

T: How do you feel seeing her react that way?

C: A bit annoyed, I guess.

T: What annoys you?

C: It's like she's looking down on me. She can be such a bully if I don't do what she says.

T: Try saying that to her. "Ana, it annoys me how much you bully me".

C: [To the empty chair]. I hate the way you bully me and put me down. Nothing I do is ever good enough for you.

T: You're never satisfied.

C: Right! It never ends. If I lose weight, you only say I need to lose more. I'm so tired of it.

T: What does Ana say to that?

C: She doesn't care. She says I always lose more weight.

T: What's happening inside now?

C: I'm sick of never feeling good enough. I'm tired of being pushed to lose more and more weight.

T: What other aspects of anorexia are you tired of? Tell her...

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