Attitudes and applications of chairwork amongst CBT therapists: a preliminary survey

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Abstract

Chairwork refers to a collection of experiential interventions which utilise chairs, their positioning, movement, and dialogue to facilitate therapeutic change. Chair-based methods are used in several models of psychotherapy, including cognitive behavioural therapy (CBT). However, little is known about cognitive behavioural therapists' use and attitudes towards chairwork. A mixed methods survey was conducted of 102 therapists who provided CBT. Overall, training in chairwork was weak amongst CBT therapists (35%). Quantitative results indicated that most therapists perceived chairwork to be clinically effective and consistent with the cognitive behavioural model, but did not feel competent using these methods. Perceived competence was highest amongst therapists who had been trained in chairwork and practised it frequently, but was unrelated to CBT accreditation or clinical experience. Qualitative feedback identified a number of factors that encouraged the use of chairwork (e.g. overcoming limitations associated with verbal restructuring methods), as well as inhibitors (e.g. therapist anxiety and limited access to training). These preliminary findings highlight a need for further research relating to cognitive behavioural chairwork and suggest that increased training in experiential interventions could go some way towards improving outcomes in CBT.

Key learning aims
As a result of reading this paper, readers should:

(1) Understand cognitive behavioural therapists' attitudes towards chairwork.
(2) Appreciate therapists' anxiety and avoidance in relation to chairwork.
(3) Identify the key factors that facilitate or inhibit the use of cognitive behavioural chairwork.

Introduction

Cognitive behavioural therapy (CBT) is an effective, empirically supported psychotherapy, which is recommended for the treatment of a range of emotional disorders (Butler *et al.*, 2006; Hofmann *et al.*, 2012). While CBT incorporates a variety of therapeutic techniques to promote cognitive-affective change, experiential methods are regarded as being amongst the most powerful (Greenberger and Padesky, 1995; Wells, 1997; Young *et al.*, 2003). Cognitive theory provides insights into why this may be the case. Dual process models such as Teasdale and Barnard's (1993) theory of interacting cognitive subsystems (ICS) propose that information processing is governed by two subsystems: a propositional code that is concerned with factual, language-correspondent 'head-level' beliefs, and an 'implicational' code that is concerned with implicit,

Table 1. Forms of chairwork

Horizontal procedures	Description
Interviews	Questioning in the role of self-parts or other persons
Dialogues	Encounters with self-parts or other persons
Dramatisations	(Re)creation of scenes from the past, present or future
Depictions	Representational measurement and mapping using chairs
Disclosures	Recounting or describing events from a second chair
Vertical procedures	
Compassionate witnessing	Compassionate observation of task engagement
Dispassionate witnessing	Decentred observation of task engagement

'heart-level' beliefs which tend to manifest as felt-senses. Similarly, Epstein's (2014) cognitive experiential model (CEM) distinguishes between a non-verbal, holistic and emotion-driven experiential information processing system, and a rational system associated with an effortful, analytic and verbal information subsystem. The implication of dual processing models has been that modifying affect-laden implicational/experiential knowledge is preferentially achieved through experiential interventions 'in which new or modified models are created' (Teasdale, 1997; p. 90). Consistent with this position, preliminary research suggests that experiential methods such as behavioural experimentation and imagery may be more effective than verbal restructuring in generating cognitive-affective change (Bennett-Levy, 2003; Hyett *et al.*, 2018).

Whilst experiential interventions are often used in CBT, few studies have explored the therapeutic applications of 'chairwork': a collection of procedures which utilise chairs, their positioning, and movement in order to facilitate here-and-now interactions with parts of the self, including internalised representations of other individuals ('horizontal' dialogues or procedures), or decentred observation of parts of the self ('vertical' dialogues or procedures) (Table 1) (Pugh and Broome, 2020). Archetypal forms of chairwork include enactments in which the client is questioned in the role of parts of the self ('interviews'); conversations between two or more parts of the self ('dialogues'); creating scenes from the past, present or future ('dramatisations'); and using chairs as representational objects to map and measure relationships ('depictions') (see Kellogg, 2019). Originating from psychodrama (Moreno, 1987) and popularised by gestalt therapy (Perls, 1973), chairwork is used for many purposes in CBT including cognitive restructuring, behavioural skills training, and, to a lesser degree, emotional regulation (Pugh, 2019a,b). Historically, cognitive therapy has viewed chairwork as a 'second-line' intervention for resistant cognitions or when verbal restructuring techniques fail (Beck, 1995; Ellis, 2001). In contrast, chairwork represents a more central method in several CBT-allied models of therapy including schema therapy (Young *et al.*, 2003), compassion-focused therapy (Gilbert, 2010), and trial-based cognitive therapy (de Oliveira, 2015).

Research examining the effectiveness of cognitive behavioural chairwork is limited, although existing findings are encouraging (Cromarty and Marks, 1995; Lipsky *et al.*, 1980). For example, studies indicate that the trial-based role play (de Oliveira, 2015) is an effective method for modifying negative core beliefs and ameliorating associated distress (de Oliveira, 2008; de Oliveira *et al.*, 2012a). Moreover, trial-based role playing appears to be advantageous in reducing fears of negative evaluation and avoidance amongst individuals with social phobia when compared with use of automatic thought records and positive data logging (de Oliveira *et al.*, 2012b). Qualitative studies have also highlighted the memorability and 'felt truth' of changes brought about through chairwork (Bell *et al.*, 2020; Chadwick, 2003). In terms of behaviour change, behavioural rehearsal through role play has proved to be a highly effective method for establishing new interpersonal skills, particularly assertiveness (Speed *et al.*, 2018).

Despite its supposed effectiveness, competency frameworks have made limited reference to the applications of chairwork in CBT. For example, Roth and Pilling (2007) discuss role playing only in the context of modifying core beliefs,[1] while process-based frameworks limit chairwork to cognitive reappraisal (Arntz, 2018; Wenzel, 2018) and interpersonal skills training (Mueser, 2018). This leads us to hypothesise that chairwork is used infrequently by practising therapists. Other research has highlighted factors that obstruct the use of evocative interventions including therapist anxiety, negative attitudes, and lack of specialist training (Bell *et al.*, 2015; Harned *et al.*, 2013; Waller *et al.*, 2012). In addition, little is known about therapists' attitudes towards chairwork, including its perceived utility and compatibility with CBT. Such an understanding would help gauge what place chairwork holds in cognitive behavioural practice, as well as potential training needs amongst therapists.

The aim of this exploratory practitioner survey was to provide data relating to cognitive behavioural therapists' attitudes and experiences of chairwork. The specific aims were to survey CBT therapists' (a) training, competency and use of chairwork; (b) attitudes towards chairwork in terms of efficacy, relevance and compatibility; and (c) the experience of delivering chairwork within CBT. The study also aimed to determine whether CBT therapists' use of chairwork varied according to their training backgrounds.

Method
Design
A cross-sectional design was used, using a self-report questionnaire which was completed by hand. A mixed methods approach was employed to provide a comprehensive picture of therapists' attitudes and experiences of chairwork, as well as to generate hypotheses about its applications in CBT. Equal priority was given to both types of data.

Participants and procedure
The participants were a convenience sample of qualified therapists working in the UK. Participants were recruited at training events facilitated by the first two authors over a 12-month period. Topics for workshops were either applications of chairwork in CBT or introductions to compassion-focused therapy. Survey questionnaires were completed at the start of training events. The clinicians consisted of 88 women and 14 men who routinely delivered CBT. Participants had a mean age of 42.5 years ($SD = 10.3$; range $= 24–71$) and reported a mean amount of time delivering CBT of 8.18 years ($SD = 5.67$; range $= 0.25–30.0$). Their mean amount of time delivering CBT was reported as 15.3 hours per week ($SD = 7.63$; range $= 1–40$). Sixty-eight were accredited CBT clinicians, 10 were accredited CBT supervisors, and three were accredited CBT trainers.

Survey questionnaire
The survey questionnaire was designed specifically for this study. The questionnaire was constructed to assess clinicians' attitudes towards chairwork in the context of CBT and personal experiences of using these techniques. The questionnaire also contained basic demographic data items and items regarding participants' professional background (see Results section). The design process consisted of developing, reviewing and refining study-specific items through discussion amongst the research team.

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[1] Role-playing techniques are paid greater attention in problem-specific competencies in CBT, most notably stress-innoculation training, although chairwork is not included as a broader therapeutic method.

Table 2. Open-ended questionnaire items

1. When do you tend to use chairwork techniques in a course of CBT, if at all? Please give details.
2. Are there any factors that make you likely to use chairwork in CBT? Please explain your answer.
3. Are there any factors that make you less likely to use chairwork in CBT? Please explain your answer.
4. Why might you use chairwork techniques (rather than other techniques) in a course of CBT?
5. Do you have any concerns or worries about using chairwork?
6. How do you think clients experience chairwork in CBT, or might/could experience chairwork?

The final survey consisted of a total of five closed-ended items and seven open-ended items. Closed-ended items consisted of the following questions, which were coded on a 5-point Likert scale: self-rated competency using chairwork in the context of CBT (1 = not competent, 5 = very competent); frequency of use of chairwork in CBT (1 = never, 5 = very frequently); perceived compatibility of chairwork and CBT (1 = not at all compatible, 5 = very compatible); perceived effectiveness of chairwork (1 = very ineffective, 5 = very effective); and the perceived value and importance of chairwork in CBT (1 = not important/valuable, 5 = very important/valuable). The remaining six open-ended items invited participants to describe personal experiences of applying chairwork within their cognitive behavioural practice (Table 2).

Data analysis

Quantitative data were analysed using SPSS software. Qualitative responses were typed and collated. The resultant data were analysed using Braun and Clarke's (2006) six-stage thematic analysis. This involved an inductive coding of the data, identifying patterns of meaning and significance, and producing a set of initial themes. These were then refined to produce a table of superordinate themes. In line with quality guidelines for qualitative research (e.g. Elliott *et al.*, 1999), the main analysis was carried out by one author (T.B.) and independently audited by a second author (M.P.) to ensure the credibility of superordinate themes and their grounding in the raw data. Differences in interpretation were negotiated to produce the final set of themes.

Ethics

The study was reviewed by the first author's research and development and information governance departments and was deemed as not requiring review by an NHS research ethics committee. Participants provided informed consent prior to completing the survey.

Results
Quantitative analysis
Clinician characteristics

Thirty-six clinicians (35%) had received formal training in chairwork and 49 (48%) had been trained in CBT-allied therapies most associated with the use of chairwork (e.g. schema therapy and compassion-focused therapy), although they had not necessarily been exposed to chairwork in those trainings.

Use and perceived value of chairwork

Table 3 shows the clinicians' perceptions of their own competence and frequency of use of chairwork, and their views of its compatibility with CBT, relevance to cognitive behavioural practice, and its effectiveness. The majority rated their own chairwork skills as weak to

Table 3. Clinicians' self-reported skill and perceptions of chairwork

Self-rating	1 (low)	2	3 (moderate)	4	5 (high)
Competence using chairwork	22	45	24	12	0
Frequency of using chairwork	35	30	30	7	1
Compatibility of chairwork with CBT	0	3	19	40	38
Effectiveness of chairwork	0	1	7	50	35
Value and importance of chairwork in CBT	0	1	17	49	30

Table 4. Comparison of accredited, non-accredited and chairwork-trained clinicians

	Accredited CBT therapist		*t*-test	
	No	Yes	*t*	*p*
Competence in using chairwork	2.35	2.23	0.49	n.s.
(SD)	(0.99)	(0.92)		
Frequency of use of chairwork	1.95	2.16	0.95	n.s.
(SD)	(0.99)	(0.92)		
CBT-compatibility of chairwork	4.40	4.06	2.05	n.s.
(SD)	(0.60)	(0.86)		
Effectiveness of chairwork	4.21	4.30	0.60	n.s.
(SD)	(0.54)	(0.68)		
Contribution of chairwork	4.16	4.10	0.34	n.s.
(SD)	(0.60)	(0.75)		
Positive attitude to chairwork	12.7	12.6	0.45	n.s.
(SD)	(1.28)	(1.93)		
	Training		*t*-test	
	No	Yes	*t*	*p*
Chairwork	1.99	2.75	4.14	.001
(SD)	(0.81)	(0.94)		
Chairwork-compatible approaches	1.94	2.59	3.73	.001
(SD)	(0.96)	(0.78)		

n.s., not significant.

moderate (88%) and did not use it often (61%). However, most regarded it as an effective intervention (91%), compatible with CBT (78%), and one which makes a significant contribution to cognitive behavioural practice (81%).

Factors associated with opinions regarding chairwork

The association of general CBT accreditation with competence in using chairwork was tested using *t*-tests (see Table 4). Those clinicians who had CBT accreditation did not feel more competent in using chairwork; did not use chairwork more often; did not feel that chairwork was more CBT-compatible; did not feel that chairwork made more of a contribution; and did not have a more positive attitude to chairwork. None of these differences was significantly different ($t < 1.70$; not significant in all cases).

In contrast, clinicians who had received formal training in chairwork perceived themselves as more competent in its application ($t = 4.14$, $p < .001$). Similarly, generic training in chairwork-compatible therapies was associated with feeling more competent in applying it ($t = 3.73$, $p < .001$).

Frequency of use of chairwork was correlated (Pearson's *r*) with perceived competence, to determine whether the extent of use of this method was linked to the perceived ability to deliver it well. This correlation was strongly significant ($r = .671$, $p < .001$). Finally, the

temporal variables (age, length of time providing CBT, number of hours per week delivering CBT) were associated with the variables detailed in Table 3 (levels of competence, etc.) and with positive attitudes to chairwork. Pearson's r was used, with a Bonferroni correction to reduce the risk of Type 1 error. None of these correlations approached significance ($r < .25$, not significant in all cases). This pattern of correlations indicates that clinician experience and frequency of use leads clinicians to view themselves as being more skilled in delivering chairwork, but that level of use and clinical caseload do not result in such perceived skills.

Qualitative analysis

The analysis of the qualitative data produced four interacting themes: 'connecting to emotion'; 'concerns about client reactions'; 'confidence and competence'; and 'from self-criticism to compassion'.

Theme 1: Connecting to emotion

Therapists' predominant reason for using chairwork was to encourage clients to acknowledge, experience and articulate their emotions. Participants were more likely to consider chairwork when clients 'struggled to connect' to their feelings or experienced a disjunction between 'head' versus 'heart' processing:

> '*I tend to use* [chairwork] *more when clients become stuck connecting to an incident or when they can 'understand' the rationality, however* [they] *cannot 'feel' it.*'

Chairwork was associated with the deepening of emotional experiencing and contrasted with verbal interventions associated with logical challenging. 'Embodied learning' and 'body work' (the use of gesture, posture and vocalisations) were identified as key factors in making chairwork emotive, immersive and effective:

> '[Chairwork] *seems to promise greater effects through dramatisation and intense emotional response as opposed to purely cognitive work.*'

> '[Chairwork moves] *from the head into the body, to make things more real.*'

Working with heightened levels of emotion was often described as 'empowering', increasing clients' agency related to their feelings and their expression. Participants also identified the benefit of using chairwork to reverse and target emotional avoidance or 'blocking' in session. Specific forms of chairwork were also valued for allowing emotions to be personified, embodied and addressed directly. Notably, chairwork was associated with facilitating healthy expressions of anger.

Theme 2: Concerns about client reactions

Despite highlighting the benefits of activating emotion, participants were concerned about overwhelming or dysregulating clients due to the emotional intensity of the method:

> '*I think they generally find it very powerful, but also highly distressing. Sensitivity and plenty of time are needed ... I think their fear makes them find it quite difficult to let go.*'

Participants feared making their clients 'worse' and 'causing more harm than good' through potential destabilisation or disengagement. This consideration interacted with service factors, such as the limited time afforded to developing soothing/grounding skills in short-term work:

'*If you can't ground person enough to self-soothe*, [chairwork] *seems too painful/hurtful.*'

The presence of a strong therapeutic relationship was deemed to be key factor in mediating and mitigating the potential for causing distress and was frequently identified as an important consideration when deciding to use the approach.

Concerns about client reactions also centred on the potential for chairwork to generate self-consciousness, embarrassment and shame. Participants suggested that some clients might 'feel too exposed', perceive the exercise as 'child-like' or 'weird', or associate the process with acting and pretence:

'*If a client sees it as acting and therefore not real for them. If they're not open to working with/ making space for some resistance about doing chairwork, i.e. willing to experiment with it.*'

Client 'scepticism' or lack of 'openness' to experiential methods was frequently cited as reasons not to use chairwork. Certain presentations were also avoided by some therapists, such as trauma, personality disorder or severe low mood (out of concern for de-stabilisation or the escalation of risk). Clinicians were also concerned that clients might become absorbed or 'stuck' in specific roles or emotions:

'*The client* [might not] *reach the point by the end of the intervention where they are able to think/feel differently.*'

Despite these concerns, the majority of participants felt that such reactions would be short-lived, part of the therapeutic process ('deepening the experience of therapy'), and ultimately helpful or 'potentially revolutionary'.

Theme 3: Confidence and competence

Participants' fears of client dysregulation were shaped by doubts about their own confidence and competence using chairwork, sometimes leading to avoidance of these interventions. Doubts were focused on technical ability, decision-making regarding when and where to use chairwork, and how to manage blocks and other difficulties arising during enactments:

'[I am] *concerned I may 'get it wrong'. Concerned I might misuse it – clients go home feeling very confused.*'

'*Messing it up. Getting stuck and not knowing how to guide the role play next.*'

Other therapists felt like an 'imposter' delivering a technique that was alien to them ('*I was never very good at acting*'). In addition, difficulties 'selling' the approach to clients and negative experiences using chairwork in the past were also identified as factors reducing its use:

'*I might get confused/they might get confused if I lose sense of* [my] *rationale.*'

Therapists' anxieties and doubts relating to chairwork were linked to a lack of coverage in their core-training or limited access to formal chairwork training. Participants also identified a professional 'stigma' linked to chairwork insofar as its supposed deviation from established models and protocols. The lack of supervisor interest and competence in chairwork was deemed to be an important factor limiting use of chairwork:

'*I suppose not being able to receive adequate supervision for when difficult emotions come up.*'

Theme 4: From self-criticism to compassion

A recurrent theme was using chairwork to both explore and target 'self-to-self relating', specifically self-criticism and self-compassion:

> '*I thought it helped reinforce a different style of self-talk. Moving chairs is likely to distinguish critical thinking from compassionate thinking more easily.*'

> '*For highly self-critical people with lots of shame. To help people learn alternative ways of self-to-self relating.*'

Participants highlighted the therapeutic value of using chairwork to differentiate internal 'voices', concretise self-self dialogues, and 'de-centre' from self-critical cognitions. In addition, chairwork helped facilitate self-compassion by developing new 'perspectives' and self-directed 'empathy', as well as new curative 'feelings' which ameliorated self-criticism. Participants frequently considered chairwork when working with low self-esteem and suggested its use was particularly helpful with negative core beliefs. Notably, compassion-focused therapy was often therapists' only exposure to chairwork.

Discussion

Whilst CBT is undoubtedly efficacious, treatment outcomes are not always satisfactory (Hudson *et al.*, 2015; Westen and Morrison, 2001). Driven by the need to develop more effective cognitive behavioural interventions, experiential methods have recently experienced renewed interest (Borkovec *et al.*, 2003; Saulsman *et al.*, 2019). Of these, cognitive behavioural forms of chairwork are perhaps most enigmatic and poorly understood (Pugh, 2019a).

This study explored CBT therapists' attitudes and experiences of chairwork. In summary, CBT therapists rated their competence and use of chairwork as low. Despite this, clinicians regarded chairwork as an effective and CBT-compatible therapeutic method. Pioneering CBT manuals have emphasised the utility of chairwork (Beck *et al.*, 1979; Beck *et al.*, 1985; Young, 1990), although its application in practice appears to be sparse. Consistent with therapist training research (Beidas and Kendall, 2010; Rakovshik and McManus, 2010), the quantitative results indicated that clinicians who had undertaken training in chairwork or therapeutic models which emphasised its use (e.g. schema therapy and compassion-focused therapy) perceived themselves as more competent and utilised these procedures more frequently. However, this was not the case for accredited CBT therapists, irrespective of temporal factors (e.g. longer durations of experience). Competency frameworks for delivering CBT indicate that chairwork and, relatedly, role play are both useful in treating certain disorders (Hayes and Hoffman, 2018; Roth and Pilling, 2007), although their importance is under-emphasised compared with other techniques (e.g. cognitive reappraisal and behavioural experimentation).

The qualitative findings contextualised CBT therapists' attitudes towards chairwork. Key foci for chairwork included emotional processing and cognitive modification, and tended to be used when 'traditional' cognitive behavioural methods proved insufficient. While research suggests that chairwork is an effective method for modifying maladaptive thoughts and feelings (e.g. de Oliveira, 2008; Greenberg and Malcolm, 2002; Paivio and Greenberg, 1995), support for chairwork as a behaviour change method is as equally strong (Lazarus, 1966; Sanchez *et al.*, 1980). It is unfortunate, then, that use of enactive behavioural methods appears to be declining amongst therapists (Speed *et al.*, 2018). The results of this study suggest that more could be done to promote the use of modelling and behavioural rehearsal through chairwork amongst CBT therapists.

The qualitative findings indicated that CBT therapists' use of chairwork was informed by overlapping conceptual frameworks: 'embodied' approaches to cognitive-affective change and

the need to achieve 'head-level' and 'heart-level' belief change. Beginning with the former, embodied approaches to CBT emphasise the reciprocal interactions between bodily events (e.g. posture, gesture and motion) and cognitive-affective experience (Hauke *et al.*, 2016). Research has supported this hypothesis, demonstrating that changes in bodily processes influence mood (Michalak *et al.*, 2012), while adaptive changes in thought and feeling can be 'anchored' to physiology through action (Bell *et al.*, 2020). Similarly, ICS has highlighted the role of bodily inputs in the maintenance of negative emotional states and underlying implicational knowledge (Teadale and Barnard, 1993). In order to bring about implicational ('heart-level') change, ICS recommends use of multisensory interventions rather than analytic techniques which primarily influence rational (i.e. propositional) processes. Thus, it appears that CBT therapists' use of chairwork is broadly consistent with theoretical literature.

Alongside contextual factors (e.g. limited experience and access to training), therapist-specific variables also influenced their attitudes and practice. In particular, therapists were often fearful of clients' negative reactions to chairwork. Therapist anxiety has been shown to obstruct the use of therapeutic procedures, particularly those that are evocative and demanding (Harned *et al.*, 2013). For example, anxious clinicians tend to favour talk-based strategies (e.g. verbal restructuring) over active interventions such as exposure (Levita *et al.*, 2016; Parker and Waller, 2019). Enactive techniques such as chairwork require both creativity and spontaneity (Moreno, 1987), which can challenge clinicians who favour certainty. Training strategies based on dual-processing theory suggest that simulated therapy exercises are effective both in terms of enhancing technical competence and violating therapists' expectations of harm through direct experience of interventions (Farrell *et al.*, 2013). Accordingly, learning chairwork through self-practice and self-reflection may offer a particularly valuable medium for building therapists' confidence and skill (Bennett-Levy *et al.*, 2001).

This is the first study to survey therapists' experiences of chairwork and requires substantial development. Given that the participants were a convenience sample, it is unclear how far these findings generalise. In order to avoid what could be an overly optimistic picture of cognitive behavioural chairwork, replication studies are needed using a larger and more representative sample. The study also utilised a non-standardised survey questionnaire which relied on self-reported practice. Moreover, the construct validity of survey items was assumed, although this is questionable. Observational studies would provide more reliable data regarding CBT therapists' application and understanding of chairwork. Finally, future studies should establish the reliability and validity of clinicians' definitions of chairwork. For example, do CBT therapists regard role play as form of chairwork or a distinct therapeutic method?

In summary, our findings provide a baseline understanding of CBT therapists' attitudes and applications of chairwork. In terms of future research, an extension of this study would be to examine client attitudes and experiences of chairwork in CBT (Bell *et al.*, 2020). There is also a need to establish the efficacy of cognitive behavioural chairwork and its change mechanisms. The qualitative results also present a variety of hypothesises. For example, to what extent does therapist anxiety affect the use of chairwork, and what are mediators and moderators of this relationship (e.g. fear of clients' expressed emotion)? Finally, we must not assume that CBT therapists' limited use of chairwork is 'bad' without better understanding for whom these interventions work, with which presenting difficulties, and at what point(s) in treatment.

Conflicts of interest. The first author of this paper is provided royalties from a related textbook.

Ethical statement. The authors abide by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA.

Data availability. The data are not publicly available due to their containing information which could compromise the privacy of participants.

> **Key practice points**
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> (1) Experiential methods are regarded as highly effective in CBT.
> (2) Therapists view chairwork as effective and compatible with CBT, but seldom use it.
> (3) Anxiety and limited training prevent greater use of chairwork, despite its benefits.
> (4) Improved access to training and additional chairwork-related research is needed.

Further reading

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