Single-session chairwork: overview and case illustration of brief dialogical psychotherapy

Matthew Pugh

Central and Northwest London NHS Foundation Trust, London, UK

ABSTRACT
Single session therapy (SST) is an increasingly popular approach to mental health treatment that aims to address clients’ presenting difficulties in a single appointment. However, experiential approaches to SST are limited. In this paper I describe the theory and practice of “chairwork” – an integrative, action-focused method of intervention centred on the concept of self-multiplicity – and outline how these procedures can be coherently applied in a single-session format. A preliminary protocol for delivering single-session chairwork (SSC) or “brief dialogical psychotherapy” is presented, alongside a case illustration that demonstrates features of this approach. Finally, directions for future research and the continued development of chairwork as a psychotherapeutic modality are considered.

Introduction
Improving the accessibility and efficacy of mental health care is a priority for health and welfare services. The need to provide psychological therapies which are cost-effective and clinically effective has led many providers to adjust their service structures in favour of brief, time-limited interventions. Perhaps the most extreme example of this, single session therapy (SST), has proved satisfactory and sufficient for a proportion of individuals seeking support. While a variety of therapeutic modalities have adopted SST, experiential approaches are under-utilised. In this paper, I describe and illustrate a novel approach to SST – “brief dialogical psychotherapy” – which is centred on the use of chairwork. The overarching aim of brief dialogical psychotherapy is to resolve problematic relationships between “parts” of the self that are linked to psychopathology (referred to as “dialogical dysfunctions”) and to promote healthy dialogical functioning. Healthy dialogical functioning describes a flexible and diverse array of integrated, organised, and largely harmonious parts that support growth and continued innovation of the self. Dialogical psychotherapy is, therefore, very much an experiential, “parts orientated” modality.

Single session therapy
SST is a complete psychological intervention, consisting of a discrete beginning, middle, and end, which attempts to address the client’s issues and goals within a single meeting (Campbell, 2012; Hymmen et al., 2013; Slive & Bobele, 2012). An approach to both treatment and service delivery, SST is predicated on two remarkable observations. First, the most common number of therapy appointments attended by individuals is one (followed by two, followed by three, and so on).

CONTACT Matthew Pugh matthewpugh@nhs.net Vincent Square Eating Disorders Service, 1 Nightingale Place, London SW10 9NG, UK
© 2021 Informa UK Limited, trading as Taylor & Francis Group
Second, many individuals find that single sessions meet their needs and circumstances (Young, 2018). This is not to say that SST should replace medium- and long-term psychotherapies. Rather, SST assumes that very brief therapeutic encounters are sufficient for some individuals (Dryden, 2020; Hoyt et al., 2018). Moreover, SST does not preclude additional meetings but assumes that single sessions will be the first and last meeting (Lee & Tratner, 2020).

Single-session interventions are described throughout the psychotherapy and counselling literature: Sigmund Freud (Breuer & Freud, 2001), Milton Erickson (O’Hanlon & Hexum, 1990), Zerka Moreno (Horvatin & Schreiber, 2015), Fritz Perls (Perls, 1969), and Robert and Mary Goulding (Goulding & Goulding, 1979) provide impressive examples. However, growing interest in SST is mainly attributable to the seminal work of Moshe Talmon, which offers rich illustrations and compelling data regarding the utility of single-session treatments (Hoyt & Talmon, 2014; Talmon, 1990). Today, multiple modalities have embraced the single-session framework, including cognitive behavioural therapy (Dryden, 2017), emotion-focused therapy (Matthews, 2018), family therapy (Hopkins et al., 2017), and solution-focused brief therapy (Campbell, 2012). However, it should be noted that SST does not ascribe to any one orientation, but describes a mindset in which the therapist attempts to tackle the client’s difficulties in one meeting (Hoyt et al., 2020, 2021).

While the models and methods utilised in SST vary, certain practice-related principles are shared (Courtnage, 2020; Dryden, 2020; Hoyt et al., 2020, 2021; Slive & Bobele, 2011; Young, 2018). Features of “single-session thinking” include:

- Treating the appointment as though it will be the last.
- Assuming that a single session is all the client needs.
- Appreciating that rapid change is possible and relatively common.
- Focusing on the client’s nominated concerns.
- Working in the absence of a case history.
- Recognising that clients know what works best for them.
- Identifying and applying client resources.

Research indicates that a significant proportion of adults and adolescents benefit from SST and are satisfied with single appointments (e.g. Aafjes-van Doorn & Sweeney, 2019; Hymmen et al., 2013; Schleider & Weisz, 2017). While small sample sizes, a lack of comparison groups, and a paucity of follow-up data have limited single-session research, existing studies indicate that SSTs are effective (Dryden, 2020).

**Chairwork**

Chairwork refers to a collection of experiential interventions which utilise chairs, positioning, movement, and dialogue to facilitate here-and-now interactions with parts of the self (Pugh, Bell, and Dixon, 2021). First utilised within psychodrama (Carstenson, 1955), chairwork is more often associated with gestalt therapy and Perls’s use of therapeutic “experimentation” (Polster & Polster, 1974; Zinker, 1977). Chairwork has since been incorporated into numerous modalities, including cognitive behavioural therapy (Pugh, 2019a), compassion-focused therapy (Gilbert, 2010), emotion-focused therapy (Greenberg, 2015), psychosynthesis (Whitmore, 2014), psychodynamic therapy (Fosha, 2000), schema therapy (Young et al., 2003), and systemic therapy (Boscolo & Bertrando, 2018), in addition to clinical supervision (Bird & Jonnson, 2020; Pugh & Margetts, 2020) and performance coaching (Passmore & Sinclair, 2020; Pugh & Broome, 2020).

Regarding applications, chairwork has been used to address a variety of difficulties. These include anxiety (Murphy et al., 2017), depression (Goldman et al., 2006), disordered eating (Ling et al., 2021), addictions (Dayton, 2005), childhood abuse (Paivio et al., 2010), bereavement (Neimeyer, 2012), domestic violence (Leal et al., 2021), stigmatisation (Boccone, 2016), and racial trauma (Lowe et al., 2012). In addition, chairwork has targeted aspects of well-being, including forgiveness (Litz et al., 2016),
gratitude (Tomasulo, 2019), self-compassion (Bell et al., 2020), wisdom (Pugh, 2019a), and existential meaning (Knittel, 2009) (see Pugh & Salter, 2021, for review).

Despite wide usage, determining the efficacy of chairwork remains a challenge. First, the sheer number of procedures that constitute chairwork complicates any kind of global evaluation of its effectiveness. Second, research has largely focused on testing common and specific factors in psychotherapy rather than particular techniques (Mulder et al., 2017). Nonetheless, studies indicate that chairwork performs well as a stand-alone intervention: two-chair methods are effective in resolving inner conflicts such as indecision, self-criticism, and “unfinished business” with other individuals (e.g. Greenberg & Higgins, 1980; Greenberg & Malcolm, 2002), while role-playing procedures have been successfully applied to interpersonal skills training and cognitive modification (Delavechia et al., 2016; Lazarus, 1966). Furthermore, research suggests that chairwork is no less effective than comparison interventions, including problem-solving (Clarke & Greenberg, 1986) and costs-benefits analysis (Trachsel et al., 2012).1

The “pillars” of chairwork

Chairwork has recently been conceptualised as resting on four “pillars” relating to its principles, processes, procedures, and process-related facilitative skills, which are the foundations of dialogical psychotherapy and coaching (Pugh & Bell, 2020; Pugh & Broome, 2020).

Pillar 1: principles of chairwork – self-multiplicity, information exchange, and transformation (SIT)

The first principle of chairwork is that our inner worlds are populated by multiple, semi-autonomous “parts”, “selves”, or “I-positions” (the term of reference adopted henceforth; Hermans, 2004). Self-multiplicity describes this “society of the mind” that encapsulates self-related parts (internal I-positions such as one’s inner critic), other-related representations (external I-positions such as one’s parents), and internalised concepts (outside-positions such as one’s religion or gender) (Hermans & Gieser, 2012). I-positions are viewed as being horizontally organised, with certain parts being central to one’s sense of self, while others are more peripheral (Polster, 1995; Stone & Stone, 1989). I-positions are also vertically organised: parts of the self may exist at lower levels of awareness (disowned or unknown I-positions), while others are able to observe the interplay of I-positions “from above” (meta-positions) (Dimaggio, 2012). Far from being pathological, self-multiplicity appears to both common (e.g. Lester, 1992) and advantageous (e.g. Csikszentmihalyi, 2013; Kleiman & Enisman, 2018). Indeed, access to multiple selves appears to have played a role in human evolution, enabling individuals to respond flexibly, effectively, and efficiently to their environments (Gilbert, 1989; Kurzban, 2010).

The second principle of chairwork is that I-positions engage in information exchanges which establish dialogical relationships between parts of the self. In other words, I-positions are capable of speaking and listening to one another. Research suggests that psychological experience is at least partly dialogical and that inner dialogue plays a role in cognitive development, executive functioning, and forms of psychopathology (e.g. Alderson-Day & Fernyhough, 2015; Waters & Fernyhough, 2017). Dialogical interactions are also subject to power dynamics insofar as certain I-positions may come to dominate others. For example, self-criticism describes a hostile dialogical relationship in which a domineering “critical self” attacks a subordinate “criticised self” (Whelton & Greenberg, 2005). Dialogical psychotherapy suggests that psychological distress arises from I-position imbalances termed “dialogical dysfunctions” (Table 1). Key dysfunctions include internal dialogues characterised by discordance (conflictual dialogues), singularity (monolithic dialogues), and chaotic interactions between I-positions (disorganised dialogues) (Dimaggio et al., 2004; Pugh & Broome, 2020).

The third principle of chairwork is that interactions between I-positions shape and transform psychological experience. Studies suggest that psychotherapy outcomes are partly linked to
changes in dialogical relationships (e.g. Detert et al., 2006), leading to the proposal that therapeutic change may depend upon dialogue between parts of the self (Gabalda & Stiles, 2020). Psychotherapy and coaching approaches prioritise different forms of “dialogical transformation” (Table 2). These include developing new “promoter” l-positions such as the “compassionate self” (“cultivation”), strengthening functional l-positions such as the “rational mind” (“consolidation”), and resolving conflicts between l-positions (“reconciliation”).  

<table>
<thead>
<tr>
<th>Table 1. Forms of dialogical dysfunction.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dialogical dysfunction</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Monolithic dialogues</td>
</tr>
<tr>
<td>Uniform dialogues</td>
</tr>
<tr>
<td>Barren dialogues</td>
</tr>
<tr>
<td>Conflicting dialogues</td>
</tr>
<tr>
<td>Disorganised dialogues</td>
</tr>
<tr>
<td>Dissociated dialogues</td>
</tr>
<tr>
<td>Silent dialogues</td>
</tr>
<tr>
<td>Disrupted dialogues</td>
</tr>
</tbody>
</table>

Adapted from Pugh and Broome (2020).

**Pillar 2: processes of chairwork – separation, animation, and talk (SAT)**

The aforementioned theoretical principles inform three complementary processes that guide the facilitation of chairwork. First, l-position(s) are selected for the enactment and then separated both verbally (the chosen l-positions are named) and physically (l-positions are placed in different chairs or spaces). Through separation, l-positions are differentiated, concretised, and characterised. Separation also helps individuals begin to dis-identify from l-positions that dominate the mind or cause distress. Most importantly, separation creates distance between l-positions so that here-and-now exchanges of information are enabled. Without this space, dialogue cannot occur (Konopka et al., 2019).

Next, the selected l-positions are enlivened. Animation takes two forms in chairwork: through embodiment (the client changes seats and speaks as the l-position) or personification (the client imagines the l-position is held in an empty chair). Embodiment tends to provide a more immersive and evocative experience of l-positions and so is usually the preferred method.

Finally, and most importantly, l-positions are invited to talk to one another or the therapist. Indeed, it is primarily through a process of here-and-now dialogue between l-positions that

<table>
<thead>
<tr>
<th>Table 2. Forms of dialogical transformation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transformation</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Assimilation</td>
</tr>
<tr>
<td>Consolidation</td>
</tr>
<tr>
<td>Cultivation</td>
</tr>
<tr>
<td>Internalisation</td>
</tr>
<tr>
<td>Organisation</td>
</tr>
<tr>
<td>Reconciliation</td>
</tr>
<tr>
<td>Innovation</td>
</tr>
</tbody>
</table>

Adapted from Pugh and Broome (2020).
Dialogical dysfunctions are resolved in chairwork (Kellogg, 2015; Konopka et al., 2019). To ensure that these interactions are as productive as possible, therapists utilise a variety of process-based facilitative skills (see Pillar four).

**Pillar 3: chairwork procedures**

Procedures refer to the specific “tasks”, “enactments”, or “dialogues” that constitute chairwork (Elliott et al., 2004; Kellogg, 2019; Kipper, 1986; Pugh, Bell, & Dixon, 2021). These procedures have been subdivided into those involving interactions between I-positions (“horizontal procedures”) and those involving distanced observation of I-positions (“vertical procedures”) (Table 3) (Pugh, Bell, & Dixon, 2021). However, therapists are encouraged to hold the taxonomy that follows lightly, lest it constrains the spontaneity and inventiveness that is central to chairwork (Levitsky & Perls, 1969; Moreno, 2008).

**Interviews.** Interviews involve questioning the client in the role of an I-position. This can be a helpful way to explore the history, worldview, motivations, and intentions of parts of the self. Examples include:

- *Intrapersonal interviews* in which the client is questioned in the role of a self-related part such as their inner critic or inner child (e.g. Stone & Stone, 1989).
- *Interpersonal interviews* in which the client is questioned in the role of another person such as an absent parent (e.g. Tomm et al., 1998).
- *Analogous interviews* in which the client is questioned in the role of a personified metaphor, concept, or life issue (e.g. Dillard, 2013).

**Dialogues.** Dialogues aim to facilitate conversations between two or more I-positions which are enacted by the client. This can be an effective way to resolve inner conflicts (e.g. indecision) and promote affiliative relationships between I-positions (e.g. self-soothing). Examples include:

- *Self-self dialogues* between internal I-positions such as the critical self (“topdog”) and criticised self (“underdog”) (e.g. Perls, 1969).
- *Self-other dialogues* involving other individuals, such as persons towards whom the client holds lingering, unresolved feelings (“unfinished business”) (e.g. Greenberg & Malcolm, 2002).
- *Self-concept dialogues* involving conversations with abstract I-positions such as one’s gender or culture (e.g. Dayton, 2005).

**Dramatisations.** Dramatisations seek to (re)create real or hypothetical scenes associated with the formation, development, and consolidation of I-positions; “selves-defining” events that “re-mind”

<table>
<thead>
<tr>
<th><strong>Table 3.</strong> Common procedures in chairwork.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Horizontal procedures</strong></td>
</tr>
<tr>
<td>Interviews</td>
</tr>
<tr>
<td>Dialogues</td>
</tr>
<tr>
<td>Dramatisations</td>
</tr>
<tr>
<td>Depictions</td>
</tr>
<tr>
<td>Disclosures</td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Questioning the coachee in the role of I-positions</td>
</tr>
<tr>
<td>Encounters and conversations between two or more I-positions</td>
</tr>
<tr>
<td>Enacting scenes from the perspective of past, present, or future I-positions</td>
</tr>
<tr>
<td>Representational mapping and measurement of I-positions and their relationships</td>
</tr>
<tr>
<td>Recounting or retelling I-position narratives</td>
</tr>
<tr>
<td><strong>Vertical procedures</strong></td>
</tr>
<tr>
<td>Compassionate Witnessing</td>
</tr>
<tr>
<td>Dispassionate Witnessing</td>
</tr>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Caring and compassionate observation of I-positions</td>
</tr>
<tr>
<td>Neutral and objective observation of I-positions</td>
</tr>
</tbody>
</table>

Adapted from Pugh, Bell, and Dixon (2021).
the client (Fadiman & Gruber, 2020). Unlike dialogues, therapists enact roles on behalf of the client during these procedures (Cukier, 2007). Examples include:

- **Historical role-plays** involving the recreation and revision of troubling events from the past (e.g. Arntz & Weertman, 1999).
- **Internal-symbolic role-plays** in which aspects of the client’s inner world are enacted, such as the experience of hearing voices (e.g. Hayward et al., 2017).
- **Behavioural rehearsal** in which new behavioural skills are practised and fine-tuned through role-play (e.g. Lazarus, 1966).

**Depictions.** Depictions utilise chairs to describe relationships between I-positions (Pugh, Bell, & Dixon, 2021). Examples include:

- **Internal maps** that depict the relationships between parts of the client’s internal world (e.g. Roodiger et al., 2018).
- **External maps** depicting relationships in the client’s external world (e.g. Dayton, 2005).
- **Measurements** that concretise the metaphorical “distance” between I-positions, such as how near or far the client is from a goal or problematic behaviour (e.g. Pugh, 2019b).

**Disclosures.** Narratives shape our identity and influence how we perceive, understand, and relate to the world (Bruner, 2002). These self-referential stories provide I-positions with content, context, and a sense of continuity: parts of the self have stories to tell and are embedded in the “plotlines” of our lives (Angus & Greenberg, 2011; Angus & McLeod, 2004). Disclosures use chairs to externalise, recount, and revise problematic narratives. Examples include:

- **Novel disclosures** in which the client uses a second chair to verbalise emotionally-significant experiences that have gone unspoken (“silent stories”) or set aside I-positions that block these disclosures (e.g. Pugh, 2019c).
- **Multi-storied disclosures** in which a second chair is used to explore exceptions to problematically fixed, global, and one-sided self-narratives (“same old stories”) (e.g. Chadwick, 2003).
- **Expressive disclosures** involving the use of multiple chairs to help the client recount emotionally-barren narratives (“empty stories”) in a more expressive manner, such as from the perspective of their different “emotional selves” (e.g. Gilbert, 2010).

**Witnessing.** While horizontal procedures facilitate interactions with I-positions, vertical procedures support the client in observing I-positions from a decentred perspective (‘depositioning’; Hermans & Gieser, 2012). “Witnessing” serves multiple functions in chairwork, such as encouraging wise reasoning, enhancing reflective processing, and supporting emotional regulation (Kross & Ayduk, 2017). Therapists concretise witnessing by asking the client to stand during chairwork and take on the distanced perspective of a caring observer (“compassionate witnessing”) or neutral bystander (“dispassionate witnessing”) (e.g. Drucker, 2013; Pugh & Broome, 2020). Unlike dialogues, witnessing involves decentred (third-person) discussions about I-positions rather than conversations with I-positions.

**Pillar 4: process skills**

Research suggests that the manner in which chairwork is facilitated has an impact on its efficacy and uptake by clients (Greenberg & Malcolm, 2002; Muntigl et al., 2017, 2020). Process skills refer to therapist-led micro-interventions that maximise client engagement, expressiveness, and immersion in chairwork. Examples include doubling (feeding the client empathically-informed, first-person
statements to repeat aloud or correct) (Hudgins & Kiesler, 1987); movement (prompting the client to switch seats when changing I-positions) (Delavechia et al., 2016); psychosomatic enquiry (asking the client to give voice to I-positions’ non-verbal communications) (Perls, 1969); and the expression of unmet needs (inviting I-positions to assert their wants and existential needs) (Greenberg et al., 1989).

Single session chairwork: challenges and opportunities

While SSC appears to be effective in addressing a range of difficulties (Conoley et al., 1983; de Oliveira et al., 2012; Kramer & Pascual-Leone, 2016; Neff et al., 2007; Trachsel et al., 2012), it also poses unique challenges. Firstly, chairwork relies on clients’ willingness to work actively and spontaneously (Kipper, 1986). Therefore, there is a need to efficiently “warm up” the client so that sessions are as productive as possible. Secondly, chairwork is emotionally intense (Holland et al., 2020; Stiegler et al., 2018). Consequently, clients have concerns about being overwhelmed or exposed (Watson & Greenberg, 2000). Thirdly, hasty and non-collaborative experiences of chairwork are likely to be confusing, shame-inducing, and counter-therapeutic (Yontef, 1993). In light of these issues, SSC would likely benefit from supplementary interventions that support clients’ safety, containment, and reflectivity. Accordingly, brief dialogical psychotherapy expands on past approaches to SSC in the following ways:

- Warm-up starts before the appointment.
- Concerns about chairwork are discussed and addressed.
- Decisions about the focus and direction of chairwork are made in collaboration with the client.
- Clear rationales are provided for the use of particular procedures.
- Learning is consolidated post-enactment.

Overview of brief dialogical psychotherapy

Brief dialogical psychotherapy consists of six phases that modulate the emotional intensity of SSC. Sessions begin with less evocative procedures (Phases one and two), before moving on to “hotter” enactments (Phases three and four), and conclude with procedures that support emotional regulation and reflection (Phases five and six). In this way, clients’ level of arousal during SSC intends to follow an inverted U-shaped course. It should be noted that certain phases of SSC may be omitted depending on clients’ needs and the nature of the complaint (e.g. Phases two and six).

Phase zero: preparing for SSC

SSTs vary in regards to clients’ entry into treatment and may entail little or no groundwork. Intake forms are often used in SST and help the client and therapist prepare for the appointment (Dryden, 2019). Before SSC, clients complete an intake form exploring their complaint, relevant background information, and goal for the session. Importantly, clients also reflect on which procedures might resolve the problem, thereby initiating the process of warm-up before the meeting. Intake forms are then analysed by the therapist. Key considerations include the client’s plot (how the client experiences the complaint), parts (I-positions related to the complaint), positionings (potential dialogical dysfunctions), procedures (enactments which might support resolution of the dysfunction), and protective factors (strengths and resources available to the client).

Phase one: starting SSC

The therapist’s tasks at the outset of SSC are four-fold: to engage the client, present a working hypothesis regarding the key dialogical dysfunction(s), deepen the client’s warm-up, and introduce
chairwork and the concept of “centre” (Sliker, 1992). Typically, SSC opens with the client summarising their complaint and their session goal. Based on this information and the content of the intake form, a “dialogical hypothesis” describing key I-positions, their relationships, and how these link to the complaint is co-constructed. Next, chairwork is described and modelled by the therapist to strengthen the client’s warm-up. Finally, the concept of “centre” is introduced: a neutral centralising space usually demarcated by the client’s original chair or position (Hermans & Hermans-Konopka, 2010). Centre serves two important functions in SSC. First, it provides a safe, “non-active” location that the client can use throughout the appointment. Second, it serves as a centralising space for building self-awareness, (re)integrating I-positions, and deciding directions for action during the appointment (Sliker, 1992; Stone & Stone, 1989).

The transition into chairwork begins by asking the client to share any concerns about participating in SSC. If the client does have reservations (which is often the case), the session proceeds to Phase two (“meeting the inner protector”), followed by Phase three (“diagnostic procedures”). If the client has no concerns, the session moves directly to Phase three.

**Phase two: building safeness (“meeting the inner protector”)**

It is not unusual for clients to have apprehensions about participating in chairwork (Muntigl et al., 2020). Accordingly, the action of SSC begins with interviewing the “inner protector” or “gatekeeper” (Hendin, 2008): the client changes seats and speaks as the I-position which knows whether or not it is safe to explore the nominated complaint. The client-as-protector is encouraged to share its concerns, offered assurances by the therapist, and asked whether SSC can proceed. If permission is granted, the protector is thanked for its cooperation and reminded that it can and should intervene if chairwork feels perilous at any point. If consent is withheld, exploring how the protector understands the complaint and its resolution becomes the focus of the appointment. Aside from putting the client more at ease, speaking with the protector also brings attention to a valuable inner resource.

**Phase three: testing the dialogical hypothesis (“diagnostic procedures”)**

If time permits, a brief “diagnostic procedure” follows the initial phases of SSC. Diagnostic procedures are short enactments or vignettes that deepen the client’s warm-up, test the dialogical hypothesis, and provide additional “action insights” into the nature of the complaint and associated I-positions (Dayton, 2005; Kellerman, 1992; Kellogg, 2015). Examples of diagnostic dialogues include:

- “Diagnostic disclosures” in which the client describes the complaint more candidly from a second chair.
- “Diagnostic interviews” in which the therapist questions the client in the role of an I-position linked to the complaint.
- “Diagnostic depictions” in which the client uses chairs to map their relationship with the complaint, presently and preferentially.
- “Diagnostic dramatisations” in which the client enacts the ending to the ideal single session, describing what has transpired.

**Phase four: facilitating a focal enactment**

By this point, the client should be sufficiently warmed up to participate in a more evocative “focal” enactment. Given that single enactments typically last somewhere between 10 and 30 minutes (e.g. Greenberg, 2007; Greenberg & Clarke, 1979), SSC tends to limit itself to one focal procedure. Focal enactments are collaboratively agreed and informed by the dialogical hypothesis, recommendations of the inner protector, and the client’s natural movement towards completion (“act hunger”)
Focal enactments usually take the form of dialogues (two-chair conversations between I-positions implicated in the complaint) or dramatisations (role-playing autobiographical scenes linked to the complaint).

**Phase five: processing the work**

Just as important as the warm-up is helping the client “cool off” towards the end of the appointment. This is achieved through witnessing: after the focal enactment, the client stands and describes their participation in SSC from a self-distanced perspective. In doing so, emotional arousal is down-regulated, and reflective processing of the session is enhanced. The therapist facilitates witnessing by asking the client-as-observer to summarise the session, the I-positions that have emerged, and key moments of learning.

**Phase six: concluding SSC**

As with other SSTs, SSC concludes with identifying one or more solutions for the client to take forward (Dryden, 2019). If appropriate, and if time permits, the nominated solution is then road-tested through dramatisation: the therapist enacts the problem in chair one while the client enacts the solution in chair two. For example, when working with procrastination, the therapist might role-play “I-as-postponing” (“You can start your work later”) while the client practices responding from a more goal-consistent I-position such as “I-as-motivated” (“I want to start my work now so I can relax later on”). Finally, an audio recording of the appointment is provided at the end of SSC to help the client consolidate their learning.

**Case illustration**

A case illustration of SSC with verbatim extracts now follows. Isabella [a pseudonym] is a white European female in her mid-forties, married with two children, who participated in a single-session appointment. The session lasted approximately 90 minutes and took place via a teleconferencing platform. Isabella reviewed and consented to the inclusion of this case illustration in this paper.

**Phase zero: preparing for SSC**

Isabella completed an intake form before her session. She described a tendency to dismiss her emotions and view these as invalid and unimportant. As a result, she found it difficult to share her feelings and access support from others. Regarding relevant background, Isabella was a sensitive child and criticised by her parents for being emotionally expressive. Her goals for the session were to feel less ashamed of her emotions and more self-caring when distressed. She identified “conversing with the part of myself that was made to feel ashamed of being upset” as a potential focus for the session.

**Phase one**

Isabella began the appointment by describing a pattern of feeling anxious, then dismissive and critical of her vulnerability. She linked this to early experiences of being disregarded by family members who “didn’t know what to do” with these feelings. As a result, she felt “alone” with her vulnerable emotions as a child and adult. A dialogical hypothesis that framed Isabella’s self-dismissal in terms of a “conflictual” internal relationship was presented:
Therapist: It makes me think there are two or three different parts of you that we might choose to work with tonight. It really depends on how the session plays out and what you think is most important. One is the vulnerability, one is the loneliness linked to the vulnerability, and I also wonder if it might be helpful to work with the part of you that makes you feel ashamed of feeling vulnerable.

Isabella: Yes.

Therapist: Because it sounds like there’s a conflict between these parts. There’s a part of you that puts you down and berates you for feeling those feelings.

Isabella: Yes …

Following a brief demonstration of chairwork, Isabella was asked to share any apprehensions about using this method:

Therapist: Having heard about what chairwork involves, is there any part of you that has concerns or reservations about this work tonight?

Isabella: I think there’s always the part of me that thinks, it’s gotten less over the years, but thinks about looking stupid or making a fool of myself. It’s smaller than it used to be but it’s still there …

In light of these reservations, the session moved on to interviewing her “inner protector”.

Phase two

Isabella shifted her chair and adopted the role of the inner protector, who outlined several concerns about participating in chairwork:

Therapist: You have a concern that when Isabella talks to me about what’s happening for her, I might not take it seriously or I might laugh at her and how she’s feeling.

Isabella-as-inner-protector: Yes. Taking it seriously is maybe a better way of saying it.

Therapist: Maybe I won’t take it seriously enough.

Isabella: Yes. Yes.

Therapist: Do you have any other concerns about Isabella doing this work?

Isabella: I don’t want her to be left alone with it. I don’t know if that’s a different part. But yes, I think that when she’s upset, she’s overwhelmed by it and gets left with it …

After validating these concerns, the protector was reassured that Isabella would be supported throughout chairwork and her difficulties taken seriously. Heartened by this, the inner protector was able to offer advice about how to make the session most helpful for Isabella:

Therapist: How can we help her overcome these feelings of shame and weakness around her emotions? I don’t know if you have any advice for me about how to do that.

Isabella: [Laughs]. I think she’s very good at dismissing them. In her head it happens so automatically. Sometimes she doesn’t even notice that she’s dismissing them. […]

Therapist: How can we help her with that?

Isabella: I think what’s been helpful in the past has been getting her to notice that she’s dismissing.

Therapist: So, if we can help Isabella slow down and notice when this is happening, and to be with her feelings, that could be really helpful for her.

Isabella: Yes. Just to be able to experience them …

Returning to centre, Isabella was comforted by the knowledge that her inner protector knew her so intimately and “looks out for me”, thus soothing some of the pain around her aloneness with emotions. Yet, at the same time, she felt anxious that her vulnerability was now exposed – “that I might be judged because someone can see the negative in me”. Returning to the dialogical hypothesis, parallels were drawn between Isabella’s concerns about judgement by others, the judgements of her family when she was a child, and her judgements of her vulnerability.
**Phase three**

Isabella agreed that it might be helpful to meet the part that judged and dismissed her emotions: after shifting her chair once more, this part was interviewed.

```
Therapist: So, you're the part of Isabella who has strong feelings about her feelings.
Isabella-as-dismissive-side: Yes. She's pathetic.
Therapist: She's pathetic for the way she feels.
Isabella: Yes.
Therapist: What's pathetic about the way she feels? [...].
Isabella: She's weak. It's just a feeling of being pathetic, and she's always crying, crying about nothing …
```

Having outlined its attitude towards Isabella’s emotions, the dismissive side was next asked about its origins. This line of questioning revealed not only the reasons for its emergence, but also its intentions.

```
Therapist: How long have you been around for?
Isabella: Wow, a long time, since she was in primary school. She was really shy when she was at nursery. She didn’t go to school until the second intake because she was so shy. Maybe as long as that. It wasn’t ok for her to be like that.
Therapist: Isabella was very shy when she was small, but that wasn’t ok. And then you showed up.
Isabella: Yes.
Therapist: What would have happened if you weren’t doing this for her, back then?
Isabella: [...] If I hadn’t had criticised her, other people would have and it would have been harsher.
```

The dismissive side went on to describe the rejecting responses of Isabella’s family when she was distressed. At this point, the dismissive clarified its purpose: “I criticise so that she doesn’t go into [vulnerability] too much, she doesn’t show it, and therefore she doesn’t get hurt and she’s not seen as vulnerable by anyone else”. Moving back to centre and separating the dismissive side, Isabella described feeling “freer” now that its protective intentions were understood: “I don’t think I’d realised that part is trying to protect me from getting more hurt”. However, protest against its constraining effects then followed: “[the dismissive side] has kept me on an even-keel on an emotional level, but also stopped me feeling the ups and downs of life … and from taking my space in the world”. Rather than being silenced, Isabella wanted to “harness its power … to turn it out, to give me voice, to help me stand up for myself”. Accordingly, addressing this conflict through a two-chair dialogue with the dismissive side was chosen for the focal enactment.

**Phase four**

The focal enactment began with Isabella switching seats and speaking as her dismissive side, directing its statements to her vacant chair.

```
Isabella-as-dismissive-side: What you’re thinking isn’t important. It’s not worth making a fuss about. It’s not worth it. It’s not worth putting yourself in the firing line of that, whatever it is that you want to say. It’s not worth doing that.
Therapist: Tell her what will happen if she does.
Isabella: It will just make it worse. You’ll be under fire. You’ll get shouted at and then you’ll be upset and that will make it worse […]. You need to keep it quiet. Whatever it is, you need to keep it quiet …
```

Returning to her original seat, Isabella responded by expressing her need to share her feelings with others and stand up for herself: “I don’t want to be quiet anymore, I don’t want to put up with everyone else’s shit, it’s made me so small in lots of ways … I need to have a voice and feel like I can stand up for myself”. Hearing this, the dismissive side appeared to soften in chair two.

```
Therapist: She says things have changed and she doesn’t need to be scared any more. What do you say?
Isabella-as-dismissive-side: I don’t know what to say to that. It feels scary to hear you want to do something different. I’m worried you’ll get hurt […]. I don’t want you to step into that.
```
Therapist: I don’t want you to feel like that. I’m scared.
Isabella: Yes, I’m scared of you doing that. I don’t want that for you. I don’t want you to get hurt like that. It feels scary to think about you doing that.
Therapist: What’s the scariest thing about doing that?
Isabella: That she’ll get hurt and there’s no-one there to help her […].
Therapist: I don’t want you to be that little girl again.
Isabella: I don’t want you to feel what I feel.
Therapist: Tell her what you feel.
Isabella: I just felt so alone with it and so scared. I was terrified to say it or make a noise …

Acknowledging the fears of the dismissive side, Isabella responded with reciprocally soothing responses from her original chair. As dialogue proceeded, opposition between the two sides was replaced by more compassionate relating, suggesting that an integration of these parts had begun:

Isabella: I get that there’s hurt from being brave and speaking up, but there’s also a lot of hurt in being small and without a full voice. It’s really confining. […] I get that you’re scared.
Therapist: How do you feel towards her when you say that, when you say “I get that you’re scared”.
Isabella: Compassion. I get her fear. I get her purpose. I get her reason to be here and I guess that I get the level of scared. It is really scary to think of me stepping out and being bigger. I think I’m more in a position now to help that small part of me manage that, because I’m an adult.
Therapist: Tell her.
Isabella: I’m an adult now and no-one can hurt me like they did. […] I can settle my feelings. I can settle your feelings. I know they’ll pass now. I can, and I have, started to reach out a bit more when I am distressed. People can help me with it now.
Therapist: If it fits, trying saying, “I can listen to you, I can take care of you”.
Isabella: I can. I can hear and feel your worry and concern for me, but I’m in a different place now. I’m an adult and I can help you with those feelings that you carry.

Reflecting on the focal enactment, Isabella described having newfound concern and compassion for her dismissive side.

Phase five

Isabella’s session concluded with “witnessing” her participation in SSC. Isabella stood and described the self-parts that had featured in session from the perspective of a compassionate observer. This appeared to consolidate her learning and intentions going forwards.

Therapist: What do you appreciate about what Isabella has done today?
Isabella-as-witness: I think it’s been great for her to take the time to do this for herself. [Laughs]. And to see the strength of that part which has been carrying on by itself for all this time, and it’s need for care now.
Therapist: And having seen and met these different parts of Isabella, having witnessed the work she’s done, what do you want to ensure that she takes from this session? What’s do you feel is most important for her to hold onto?
Isabella: I think the good intention of that dismissive part. And I think the fear of changing, in terms of knowing that’s what that part carries, that real fear of changing. But being an adult now, she’s able to hold some of that for it and be compassionate to that part, so that part doesn’t have to carry it by itself.
Therapist: And I wonder, as another of Isabella’s resources, if there’s any way you can make sure she does that going forwards? How can you help her bring the work that she’s done into her life? […].
Isabella: I think spending time with that part, listening to that part, acknowledging that part’s fears and worries and upset, and being with it …

Post-intervention feedback form

Isabella completed a feedback form one week after her session. She rated the session as “far exceeding expectations”, “fully meeting the goal for the appointment”, and “partially resolving” the broader issue of changing her relationship with her emotions. She described SSC as “an enlightening experience” in which she had gained “new insights into the parts I thought I knew” and developed her capacity for self-compassion. Isabella identified meeting her inner protector (Phase two) and the
focal enactment (Phase four) as the most helpful parts of the session. She felt that the extended length of the session was also helpful: “although it was a 90-minute session, the time went quickly … Every moment was therapeutic”.

Post-intervention reflections

Chairwork helped Isabella achieve her session goal. Interviewing the critical-dismissive side (Phase three) provided her with an understanding and appreciation for this I-position in the context of her early experiences (Stone & Stone, 1989). By clarifying the concerns and motivations that drive self-critical I-positions (i.e. correction and survival of the self versus persecution and destruction of the self; Gilbert et al., 2004; Stone & Stone, 1993), interview procedures inform which chairwork procedures ought to follow (Boecking & Lavender, 2020). For Isabella, interviewing the dismissive side revealed its underlying anxieties and protective intentions, thereby laying the foundations for more compassionate relating in the later stages of SSC. Indeed, research suggests that interview procedures often stimulate compassion for I-positions, including those that cause distress (Ling et al., in press). In light of Isabella’s conflictual relationship with her dismissive side, a dialogue procedure was chosen for the focal enactment. Consistent with task analyses of two-chair self-evaluative splits (e.g. Greenberg, 1983), Isabella’s expressions of sadness and associated needs as the dismissed self (chair one) led to a gradual softening in her dismissive self (chair two), culminating in mutual expressions of support and compassion. Reconciliation between these polarised I-positions appeared to have been reached by the end of the session.

As is often the case with SSC, a number of other procedures could have been pursued in the session. For example, Isabella’s fears about showing vulnerability within the therapeutic relationship (Phase two) could have been explored by asking her to “play the projection” (Levitsky & Perls, 1969). To illustrate, Isabella could have been asked to change seats and enact the “judgmental therapist” she anticipated. Links between this expectation and other relational experiences would have then been explored (Therapist: “As you enact this judgmental therapist, does it remind you of anyone you have known? If it is not your experience of me, where do these expectations come from?”). Alternatively, historical role-play (Arntz & Weertman, 1999), interviews with her internalised parents (Goulding & Goulding, 1979; Tomm et al., 1998), or empty-chair dialogues for resolving unfinished business (Greenberg & Malcolm, 2002) may have helped resolve the attachment-related injuries underlying her self-dismissal. Indeed, it is not uncommon for distressing parent–child interactions and conflictual relationships between I-positions to be related to one another (Siegel, 2020; Young et al., 2003). Given that multiple routes to resolution arise in SSC, collaborative decision-making is vital to working effectively within the constraints of a single session.

Discussion

The variety of frameworks used to deliver SST is growing. Chairwork encapsulates a collection of powerful experiential methods that are feasible and effective in brief therapeutic encounters (Lee & Tratner, 2020; Matthews, 2018). A theoretically-informed framework for conceptualising and delivering chairwork-centred therapy (“brief dialogical psychotherapy”) in a single-session format has been described in this article.

Practising and participating in chairwork can be demanding (Pugh, Bell, Waller, et al., 2021; Stiegler et al., 2018), particularly so in single-sessions. For the therapist, SSC requires an understanding of how chairwork is applied across orientations and presenting difficulties, and the ability to work in a creative and improvisational manner. Adequate training, supervision, and competency using chairwork is vital, therefore. For the client, chairwork stimulates vulnerable and often intense emotions. Given the potential for (re)traumatisation, therapists must ensure that individuals can make an informed decision about the appropriateness of SSC and possess the skills necessary for managing intense affect (Elliott et al., 2004; Matthews, 2018). Information sheets, screening of intake forms,
working with the inner protector, demarcating “centre” as a safe space, and witnessing help minimise these risks and safeguard clients’ well-being. Additional sessions should also be available (either with the therapist or elsewhere) if further support is needed.

Like other SSTs, SSC aims to meet the needs of individuals seeking brief therapeutic interventions and for whom a single session might be sufficient. However, deciding who is likely to benefit remains a “difficult if not impossible” question (Young, 2018, p. 48). Several contraindications for chairwork have been presented. These include an inability to tolerate high levels of affect; difficulties symbolising emotional experiences; and the presence of suicidality, self-harm, and highly aggressive behaviour (Elliott et al., 2004; Pos & Greenberg, 2012). SSC is also unlikely to resolve complex difficulties such as multiple traumas and entrenched emotional disorders (e.g. chronic depression) if these are the nominated complaint. General contraindications for SSTs are also applicable to SSC, including difficulties establishing trusting relationships with professionals, preoccupation with abandonment, and individuals who request (or need) longer-term therapy (Dryden, 2019). Regarding suitable complaints, Dryden (2020) suggests that common “emotional problems of living” such as dilemmas, relationship tensions, and non-clinical emotional difficulties (e.g. guilt, hurt, and envy) are ideal for SST.

Given that brief dialogical psychotherapy is in its infancy, studies are needed to evaluate its acceptability, efficacy, and refine the SSC protocol. For example, certain phases of SSC (e.g. road-testing solutions to the problem) may prove superfluous or an excessive burden on time. In addition, due to pandemic conditions, SSC is yet to be piloted outside of online therapy. Research suggests that tele-chairwork can be just as productive as its face-to-face counterpart, but requires adaptations (Pugh, Bell, & Dixon, 2021). Examples include greater use of direction to structure enactments, increased verbalised empathy to compensate for reduced non-verbal communication, and creative use of single chairs. Tele-chairwork may also impact clients’ experience of chairwork, both positively (e.g. increased disinhibition, immersion, and comfort when working in familiar environments) and negatively (e.g. reduced emotional involvement) (Feldman & Liu, 2020; Hudgins, 2017; Pugh, Bell, & Dixon, 2021). Accordingly, studies are needed to determine how well SSC translates to face-to-face appointments. Also, how SSC compares to abridged versions of established therapeutic approaches that utilise chairwork (e.g. single-session emotion-focused therapy; Matthews, 2018) remains to be seen.

Psychotherapy is steadily moving towards a conceptualisation of the self as complex, multiple, and dialogical. This article has presented an experiential approach to SST, which is grounded in the concept of self-multiplicity and utilises chairwork as the principal method for working with minds within the mind. At the very least, it is hoped that SSC highlights the therapeutic potential of inviting individuals to embody, enact, and engage their difficulties more directly during brief therapeutic encounters.

Notes

1. For more comprehensive reviews of chairwork-related outcome studies, see Elliott et al. (2004) and Pugh (in press).
2. It is worth noting that strengthening a single, superordinate I-position represents just one of several transformations, although this is the focus for many psychotherapies. For a thorough critique of this “single self assumption”, see Fadiman and Gruber (2020).
3. SSC intake forms can be accessed on the following webpage: www.chairwork.co.uk/single-session-chairwork.

Acknowledgements

The author receives royalties from a textbook related to the topic of this article.
Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

Notes on contributor

Matthew Pugh is a Clinical Psychologist, Cognitive Behavioural Psychotherapist, Advanced Schema Therapist, Voice Dialogue Facilitator, researcher, and chairwork practitioner. He is employed as a Senior Clinical Psychologist (NHS) and Teaching Fellow (University College London), alongside working in private practice in the UK. He is the co-director of www.chairwork.co.uk and the author of “Cognitive Behavioural Chairwork: Distinctive Features” (Routledge). His interests relate to self-multiplicity and the applications of chairwork in psychotherapy and coaching.

Data availability statement

Data presented in this paper (verbatim extracts and post-intervention feedback relating to the case study) cannot be shared in the interests of confidentiality and anonymity.

References


