With Love and Intensity: Some Reflections on Chairwork, Harm Reduction Psychotherapy, and the Treatment of Addictions

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I have been, and I continue to be, horrified by the disastrous impact of addictions on the mind, body, spirit, freedom, and beauty of human beings. This distress has been a driving force in my work as an Addiction Psychologist, as a Harm Reduction Psychotherapist, and as a Chairwork Psychotherapist.

In the face of this, I have been centrally focused on three overlapping questions: How do people change, heal, and transform their lives? What are the psychological and psychosocial *Mechanisms of Change* that are involved? and How can I utilize them in my psychotherapeutic work? In my efforts to answer these questions, I have had deep encounters with many different forms of healing and psychotherapy; I have also had the opportunity and the great privilege of being able to take part in a series of collaborations with my friend and colleague, Andrew Tatarsky, the creator of Integrative Harm Reduction Psychotherapy (Tatarsky & Kellogg, 2012). The outcome has been my efforts to integrate the wisdom of Harm Reduction Psychotherapy with my practice of Chairwork Psychotherapy (Kellogg & Garcia Torres, 2021).

Historically, Harm Reduction Psychotherapy was a sea change in our understanding and treatment of people wrestling with addictions or problematic substance use. Some of its benefits are:

1. It means that therapists can simply love their patients[1].
2. Clinicians can be more relaxed as they no longer need to take the stance that they know what is right for their patients; instead, they can work with them and collaborate on the creation of goals and the strategies needed to attain them.
3. It accepts that while some patients will make rapid and dramatic changes, others will want to engage in a process of gradual change; "Any Positive Change" is accepted as a form of progress and success (Bigg, 2001).
4. It was the first psychotherapy that effectively understood that many patients will need to work on their addictive behavior and on the psychological and emotional pain and anguish that underlie and drive these behaviors in an integrated and empowering manner. It embraced the idea that experiences of trauma and self-hatred may need to be addressed before the patient will be willing to engage with their substance use issues.
5. It understands that long-term recovery – whether involving drug use stabilization, moderation, nonaddictive use, or abstinence – is built on the creation of meaningful and rewarding identities that will conflict with and replace those that are based on the addictive use of substances (Kellogg, 2019).

Harm Reduction Psychotherapy, like other forms of psychotherapy, places a central emphasis on developing a strong therapeutic relationship with each patient. Erich Fromm, in *The Art of Loving*, defined Love as "the active concern for the life and growth of that which you love" (Fromm. 1956, p. 26). I think this is a very good stance for a therapist to take toward their patients.

In turn, many patients who are addicted or who have a problematic relationship with substances, are living with a great deal of pain – pain that has often been there for a

long time. This suffering may have roots in their personal histories, it may be related to their being members of historically oppressed or marginalized communities, or it may involve some combination of the two. Substance use, then, can be understood as a way of coping, as a kind of personal medicine, to help them survive in the world. One of the problems, however, is that this way of coping has become "unmoored" – to use a term from the work of Patt Denning and Jeannie Little (Denning, 2000) – and has taken on a life of its own. This means that the therapy will challenge both the patient and the therapist to be able to flow back and forth between the underlying suffering, on the one hand, and the challenge of managing any ongoing substance use to minimize its harm and danger – as best as possible.

Chairwork was created by Jacob Moreno as a part of his Psychodrama method (Moreno, 2019); it was then re-envisioned and further developed by Friederich "Fritz" Perls, the creator of Gestalt Therapy in the 1960s (Perls, 1969). It has since been utilized and adapted by psychotherapists from many different traditions. I discovered the extraordinary beauty and power of Chairwork in 2001, and I fell in love with it (Kellogg, 2014). An elegant, flexible, and powerful method of healing, it has been the central focus of my therapy practice ever since.

Chairwork is fundamentally based on Multiplicity of Self or the understanding that all people contain what has variously been called parts, modes, voices, or selves within them, and that each of the parts has their own history, roles, and messages. While most of these parts have good intentions, others are internalizations of abusive figures that live inside the person with malevolent intent. While the parts of most people are somewhat out of balance, in psychopathological states, such as depression, anxiety disorders, traumatic reactions, personality disorders, and addictions, there is a much greater degree of imbalance. Given that, the "True North" of the psychotherapy process is to help strengthen the part of the self that Freud called the Ego (Freud, 1969) and what Chairwork Psychotherapists call the Inner Leader (Kellogg & Garcia Torres, 2021). As this part gets stronger, the individual will: (a) grow in their capacity to engage in emotional self-regulation by becoming better able to tolerate and successfully manage painful emotions and stress; (b) have better and more successful relationships with other people; and (c) be able to lead a self-directed life – a value-based life that is meaningful, assertive, and effective (Kellogg & Tatarsky, 2012). What I find to be strikingly synergistic about this is that as the Inner Leader gains in strength and power, the patient will begin to regain their freedom, and their substance use will become more regulated, the inner storms related to trauma and self-hatred will start to abate, and problematic interpersonal and coping behaviors – such as passivity, rage, aggression, dissociation, and grandiosity – will lessen as well. Again, this is why I see the ongoing development of the Inner Leader as the "True North" of the therapeutic process.

In terms of the actual clinical work, Chairwork Psychotherapy generally takes three forms. In the first, the patient sits in one chair and imagines someone from their past, present, or future in the chair opposite and talks to them. This could be a deceased grandfather, a partner or spouse, or an unborn child; this dialogue is often used when there is "unfinished business" or unresolved issues with other people. In the second, the patient moves to another chair and shares, in part or in whole, difficult or traumatic stories and memories. In the third, the patient moves to different chairs to: (a) give voice to the different parts, and (b) create dialogues between these parts and the Inner Leader.

Each of these can be used as forces of healing within the Harm Reduction Psychotherapy framework.

For example, ambivalence – or mixed feelings about the use of substances – is often at the heart of the addictive experience. Using the Multiplicity of Self model, this can usefully be reframed as a conflict between two parts. Building on this, a Chairwork encounter can be created between these two parts. For example, using an imaginary patient named Harper, I would begin by working with Harper to make a list of the positives of continuing to use ("Continue) and the positives of making some kind of change ("Change") – however defined. The Continue side often affirms that the substances provide them with pleasure while also helping them to decrease pain and suffering; the Change side will often include anxiety about what the substances are currently doing to them and taking from them; they may also express a desire for a different and a better life.

To begin the Chairwork, Harper would be invited to move to Center or the Inner Leader chair. In this dialogue structure, there would be two chairs in front of them facing each other. Harper would then decide which chair would embody Continue and which would embody Change. Given that it is often useful to start with the status quo, Harper could go to the Continue chair and speak the truth of that part: "I want to keep using. I am hurting. I do not see how I would function without the drugs – they keep me going. I do not want to make any changes right now. I am not ready." They would then move the Change chair and embody that perspective: "I am not ready to stop either, but this is not working. I am scared; there must be a better way. I want something different." The idea is for Harper to go back and forth five or so times – giving voice to each perspective as powerfully and as emotionally as possible. I often invite them to stand behind each chair as this would enable them to speak with greater authority and power.

After this is done, Harper would return to Center or the Inner Leader chair and be invited to feel the impact of the dialogue. It can be helpful for them to assess the relative weight of the two parts: e.g., 50:50, 60:40; 90:10, etc. Having taken in this information, Harper can then decide what if anything they would like to do. This could include taking no action while continuing the conversation, monitoring the experience more closely, engaging in some kind of substance use management, or moving to a more formal moderation structure. This work is clearly aligned with the values of Harm Reduction Psychotherapy; while the therapist strives to create an emotionally compelling and intense encounter, the patient retains the freedom and ability to make an emotionally informed decision as to their next step or course of action.

As Andrew Tatarsky has affirmed, Harm Reduction Psychotherapy is a trauma-centered therapy (Tatarsky & Kellogg, 2010), and Chairwork can be particularly useful in working through traumatic experiences. With a patient who wants to therapeutically engage with a difficult experience from the past, I would begin by having them sit in Center or the Inner Leader chair. They would then be invited to move to another chair and to tell a difficult story, a troubling memory, or a fragment of a memory in the *third person*. For example, if Harper had been in a car accident, they would be asked to tell the story of their car accident in the *third person*: "Harper was in a car accident, and these are some of the things that happened to them" rather than in the *first person*: "I was in a car accident, and these are some of the things that happened to me." After they told the story the first time, I would encourage them to stand up, move around, shake it off, and sit

down and tell the story again. We would go through this process three or four times. What is striking about this process is that more details often emerge with each iteration; this is a sign that integration is taking place – which means that the person is beginning to heal. The *third person* approach is also helpful because it allows the patient to get more space from the trauma – which can make it less overwhelming and easier to tell. In the world of addiction and problematic substance use, many trauma stories are quite complex and tragic, and patients may feel deeply responsible for some of the things that happened and great shame about some of their actions; the *third person* storytelling method can help reduce these feelings and make these difficult narratives easier to approach.

As a next step, I would invite Harper to return to Center, and I would put several chairs in front of them. Depending on the specific details of their history, these chairs could represent and embody people who hurt them, people who knew that they were being mistreated and did nothing to protect them, and their younger self – the self that was the victim of the abuse. Harper would be encouraged to express his anger, fear, grief, and love – as appropriate – to each of these people. This can be a very powerful experience as many people have never had an opportunity to express these thoughts and feelings. Of note, it is not uncommon for those who went through childhood abuse to have difficulty expressing love, care, and compassion for their child self. When this happens, it is important that the therapist step in and speak directly to the child self – acknowledging what they went through with care, affirmation, and compassion. It can be a profound and healing experience for patients to hear other people talk about them in this way.

The experience of addiction is often filled with regret about past decisions and past actions – which may not only be a source of deep pain, but also an impediment to reclaiming and transforming one's life. If this were the case with Harper, I would first clarify the specific circumstances that they are upset about and the age that they were when these occurred. Adapting Tian Dayton's *Life Cycle Role Reversal* model (Dayton, 1994), I would then invite them to sit in Center – in the Inner Leader chair – and imagine their younger self in the chair opposite. They would first be invited to speak to their younger self and give voice to the distress that they are feeling about what happened in the past. I would then ask Harper to switch chairs, to do a *role reversal*, and "become" their younger self. I would then interview this younger self to get their understanding of what they were going through at the time and how those decisions made sense to them. It is important that this work be done in an investigative manner – with the goal of seeking to understand rather than to be confrontational or critical. When this feels complete, I would ask Harper to move back to Center, to take a minute to let what the younger self said touch them, and then tell the younger self what they heard them say about the situations and challenges that they were facing. I would seek to encourage Harper to express compassion for their younger self. In general, I repeatedly emphasize the tragic nature of the addiction journey – a journey which leads many good people, under the influence of drugs or the compulsion of addiction, to do things that they find to be morally reprehensible – things that they never thought that they could or would do. Louise Hay, in *The Power Within You*, wrote: "There is no reason to beat yourself up because you didn't do better. You did the best you knew how" (Hay, 1991). Similarly, Maya Angelou said: "You did what you knew how to do, and when you knew better, you

did better" (Winfrey, 2011). This is a challenging yet fundamentally healing perspective, and it is the spirit that I seek to embody in myself and cultivate in my patients.

While it is clear that Chairwork Psychotherapy can be a profoundly transformative experience, we are still left with the questions: How does Chairwork work? How does it help people heal and transform their lives? I think that there may be three core factors. The first is *externalization* or the process of taking internal processes and putting them outside of the self so that they can be observed and engaged with. The second is that Chairwork involves the dimension of space which allows for creative and meaningful encounters between different parts of the self. The last is that the high levels of emotional arousal and intensity facilitate the resolution of traumatic experiences and the rebalancing of inner parts.

Harm Reduction Psychotherapy is, for me, a profoundly Humanistic and compelling framework for working with patients who are wrestling with addictions or problematic substance use. Chairwork Psychotherapy, in turn, is one of the more powerful and flexible forms of psychotherapy. The parts model can provide great therapeutic clarity as to the forces at work within the individual, and the emotional intensity of the dialogues can help patients not only work through past traumas, but also rebalance the forces within them. It is my hope that this work will spread and bring liberation to those who are trapped in the prison of addiction.

Endnote

[1] Most Harm Reductionists reject the use of the term "patient" – preferring terms like "client" or "people who use drugs" instead. I believe this is rooted in a desire to challenge the power or "expertise" differential that has traditionally existed in psychotherapy and addiction treatment settings; I think that it also reflects a movement to de-pathologize substance use itself. While I resonate with these concerns, I also believe that the deep suffering and profound devastation that is a central and defining part of the addiction journey is, ironically, often trivialized. It is for this reason that I use the term "patient;" it is my way of acknowledging the profundity of the experience and my deep respect for them as individuals.

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