# Bringing It to Life: Using Chairwork and the Four Dialogues in Schema Therapy

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*"Role playing can be done as animals, spirits, delusions or hallucinations, voices, body parts, ideas, visions, the departed…." – Zerka T. Moreno (2008, p. xi)*

## A Brief History of Chairwork

Two of the distinct hallmarks of Schema Therapy are: (1) its emphasis on conceptualizing patients as containing different parts or modes; and (2) the central role of experiential methods – specifically imagery rescripting and Chairwork – in the treatment of patients (Rafaeli, Bernstein, & Young, 2011; van der Wijngaart, 2021; Young, Klosko, & Weishaar, 2003). What, then, is Chairwork? At its most basic, Chairwork takes two 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 (Perls, 1969). In the second, the patient moves to different chairs and gives voice to different parts which enables these parts to dialogue between or among themselves "with love, desire, fear, and courage often emerging as core themes" (Kellogg & Garcia Torres, 2021, p. 172).

Chairwork was originally a technique used in Psychodrama – an experiential form of psychotherapy that was created by Dr. Jacob Moreno (2019; Z. Moreno, 2012). Chairwork, as is it practiced in Schema Therapy, is more closely connected to the work of Dr. Frederich "Fritz" Perls, the creator of Gestalt therapy (Perls, 1969, 1970, 1973; Perls, Hefferline, & Goodman, 1951). Starting in the early 1950s and continuing to the early 1960s, Fritz Perls was a regular attendee at the open Psychodrama sessions that Jacob Moreno had at his institute in New York City (Z. Moreno, 2012). In short, Perls learned Chairwork from Moreno, but then adapted it to his own purposes and therapeutic philosophy. One major shift that he made was that he used it within an individual therapy context, rather than as a part of a group therapy.

In the early 1960s, Perls went to California and began giving public talks on his Gestalt Therapy model. As a part of this, he invited volunteers onto the stage and did Chairwork with them before a live audience. These demonstrations proved to be enormously compelling and popular, and they became an essential part of what he called his "circuses" (Shepard, 1975). Building on this, he went on to make Chairwork a core part of his workshops and weeks-long training experiences at the Esalen Institute and elsewhere (Anderson, 1983; Kellogg, 2014; Perls, 1969). By the time of his death in 1970, Fritz Perls was world-famous, and Gestalt Therapy had emerged as a compelling form of Humanistic-Existential Psychotherapy; this was, in large part, due to his extraordinary use of Chairwork.

Following his death, Chairwork was adapted and re-envisioned by numerous therapists from a wide range of therapeutic schools or approaches. In addition to Dr. Jeffrey Young's Schema Therapy (Young et al., 2003), these included Redecision Therapy (Goulding & Goulding, 1997), Voice Dialogue (Stone & Stone, 1989), Emotion Focused Therapy (Greenburg, Rice, & Elliott, 1993), Cognitive Behavioral Therapy (Goldfried, 2006), Compassion Focused Therapy (Gilbert, 2011), and Transformational Chairwork Psychotherapy (Kellogg, 2014).

**The Four Principles and the Four Dialogues Model of Chairwork**

In 2018, Kellogg discovered the *Four Dialogues* which not only dramatically simplified the practice of Chairwork, but also made a free-standing Chairwork Psychotherapy possible for the first time (Kellogg, July, 2018; Kellogg & Garcia Torres, 2021). The *Four Principles* are the foundation of the Four Dialogues approach, and they are:

1. It is clinically useful to understand people as containing different parts, modes, voices, or selves.
2. It is healing and transformative for people to give voice to these different parts.
3. It is also healing and transformative for people to enact or re-enact scenes from the past, the present, or the future.
4. The ultimate goal of Chairwork, the "True North" of the work, is the strengthening of the Healthy Adult Mode.

The Four Dialogues, in turn, are: *Giving Voice*, *Internal Dialogues*, *Telling the Story*, and *Relationships and Encounters* (Kellogg & Garcia Torres, 2021). Traditionally, Gestalt Therapy used the terms "two-chair" and "empty chair" to describe the basic Chairwork dialogue structures; Kellogg (2004) argued that it would be more useful to use the terms *Internal* and *External* as these terms reflected the clinical focus of the dialogue work; the Four Dialogues can be seen as growing out of that conceptual shift.

*Giving Voice* is deeply rooted in Gestalt Therapy (Beisser, 1970) and Voice Dialogue (Stone & Stone, 1989), and it is the dialogue structure that is probably least familiar to most therapists. It takes the form of: *"I would like to invite you to move to this chair and I would like you to speak from your heart and speak from your pain"* (Kellogg, February, 22, 2020, p. 1). It is an approach that might be considered when a patient says such things as: "There is a deep grief within me," or "There is a part of me that wants to cut myself as soon as I leave the session." In the first case, we might ask the patient to move to another chair, to treat the feeling as if it were a part (e.g., "the sad part"), and to go more deeply into it. Staying with, experiencing, expressing, and amplifying an emotion – especially a difficult one – can be healing (Beisser, 1970); it may also serve to uncover the stories or parts that are at the heart of the experience. In the second, the therapist can interview a part to better understand its history, purpose, and function in the patient's life – both past and present. Here, understanding is the goal; the part is not challenged and there is no attempt to change or fix it in any way.

*Internal Dialogues* involves various encounters between different parts of the self. For example, the therapist can say to the patient: *"You seem to be of two minds about the project. I wonder if you would be willing to go to this chair and speak from the part that wants to go forward with it and then to this chair and speak from the part that is having second thoughts"* (Kellogg, February 22, 2020, p. 1). *Telling the Story*, in turn, encompasses the experience of trauma and difficult memories. The clinician might broach this by saying: *"I sense that holding this secret inside for so long has been a terrible burden. If you are willing, I'd like you to move to this chair and tell me the story of what happened"* (Kellogg, February 22, 2020, p. 1). Lastly, *Relationships and Encounters* involves the interpersonal world; this dialogue – which involves two or more chairs – can be initiated in this manner: *"I can sense that you are still very stuck – even though the relationship ended two years ago. I would like to work with this if I may. I'd like*

*you to imagine her sitting in this chair and I would like you to talk to her and tell her what you are feeling"* (Kellogg, February 22, 2020, p. 1).

## The Therapeutic Relationship and Limited Reparenting

Chairwork, like other experiential methods, is conducted within the context of a strong therapeutic alliance. In Schema Therapy, this takes on a particularly intense form known as *Limited Reparenting*. Limited Reparenting challenges the therapist to provide the emotionally resonate experiences that a "good parent" would normally give to a child in pain – within the ethical limits of standard clinical practice (Rafaeli et al., 2011; Young et al., 2003). Within a Chairwork framework, as will be explored below, this takes the form of the therapist battling negative forces within the patient and in their life, providing compassion for the wounded or Vulnerable Child Mode, and affirming the growing strength and power of the Healthy Adult Mode. It also involves the use of *deepening techniques* or working with patients to: (1) use language that is empowering; (2) use repetition to increase the emotional intensity and power of what they are saying; and (3) use alternations in volume to amplify the dramatic components of the experience (Kellogg, 2014). Through this process, Limited Reparenting provides patients with more positive experiences and emotions – not only those of being securely attached, accepted, and cared for, but also feelings of competence and joy (Fassbinder & Arntz, 2019). Through this intense relational encounter, the patient will, over time, begin to internalize the affective and caring attitude of the therapist and incorporate it into their own Healthy Adult Mode. This will allow them to: (a) become increasingly compassionate and protective toward themselves; (b) develop skill at accepting the activation of intense emotions; (c) replace harmful behaviors with more adaptive ones; and (d) generally have more resources for dealing with stressful or problematic situations in a healthy way. In short, the patient will experience, accept, and integrate the therapist as stable and secure attachment figure (Finogenow, 2021).

## Schema Therapy and the Eight Chairwork Dialogues

As noted above, Schema Therapy is an experiential therapy and Chairwork has come to play an increasingly central role in the practice (Flanagan, Atkinson, & Young, 2020; Heath & Startup, 2020; van der Wijngaart, 2021). There are eight Chairwork dialogues that can be seen as the essential foundation of a Chairwork-informed Schema Therapy. These are: (1) *Evidentiary Dialogues*; (2) *Mode Interviews;* (3) *Cost-Benefit Analyses;* (4) *Mode Dialogues*; (5) *Trauma-Centered Chairwork/Third-Person Storytelling*; (6) *Trauma-Centered Chairwork/Confrontation Dialogues*; (7) *Relational Self Dialogues;* and *(8) Working Through the Therapeutic Impasse.*

## The Rhombic Dialogue

Building on work by de Oliveira (2016), schemas and modes can be usefully understood within a dialogical framework. This means that instead of seeing a schema as a belief, the therapist and patient can envision this as a person or a part arguing, affirming, or making the case for a certain perspective as to the nature of the patient, the nature of the world, and/or the right rules for living. This reframing allows the schema therapist to work with the schemas and modes in a similar manner; that is, the Healthy Adult Mode can now engage with the part that embodies

the schema directly (see also Roediger, 2018). Reflecting this, the *Rhombic Dialogue* is a four-chair dialogue structure that facilitates a much more complex and emotionally engaging way of challenging problematic schemas and modes (Chesner, 2019; Kellogg, October 2019, 2022; Pugh, 2019).

**1. Evidentiary Dialogues**

In a classic intervention from Schema-Focused Therapy, the patient and therapist first identify the underlying schemas and then look for the current and historical evidence that both supports and challenges the *validity* of the schema (Rafaeli et al., 2011). Drawing from the classic *Schema Therapy* book (Young et al., 2003), the case of Shari can be used to model an *evidentiary dialogue*. Shari, a psychiatric nurse, had a profound *defectiveness/unlovability* schema. Working with the therapist, she was not only able to clarify the current and historical evidence that supported the schema, but also was able to find evidence to challenge and, perhaps, disprove the schema. The evidence that supported the schema included: "No one ever loved me or cared for me when I was a child;" "I'm awkward, stilted, obsessive, afraid, and self-conscious with other people;" and "I get too angry inside" (Young et al, 2003, p. 95). The evidence that was in opposition to the schema was: "My husband and children love me;" My patients like and respect me;" "I'm sensitive to other people's feelings;" "I try to be good and do the right thing. When I get angry, it's for good reason" (Young et al., 2003, p. 96).

Using a *Rhombic Dialogue* structure, Shari would begin in Center or the Healthy Adult Mode chair. Six or seven feet away and directly in front of her, there would be the Schema chair – which would be an imagined embodiment of the belief that she was defective and unlovable. At 45 degrees to the right and left and about three or four feet away are two chairs that not only face each other, but also are perpendicular to the Healthy Adult Mode and Defectiveness Schema Chair Axis. One chair would embody the evidence that supported the schema and the other would embody the evidence that the evidence was false and that she was not, in fact, defective and unlovable.

To begin, Shari would be invited to start in the Healthy Adult chair. It is good to begin with an anchoring affirmation - "I am Shari, I am the Healthy Adult mode, and this is my life!" That can be repeated a few times to give it more authority. Using *role reversal* (Dayton, 2023; Moreno, 2019), she would then move to the Schema chair and "become" the schema. Speaking from its perspective, she would say something along the lines of: "Shari – you are flawed, you are awkward, you are weird, you are different. No one will ever accept you. You are so different that you are fundamentally unlovable. You should give up any hope of people liking and accepting you" or whatever arguments the schema wants to make. The more emotionally and intensely the schema speaks, the better.

She would then be asked to move back to the Healthy Adult Mode chair for a minute to take that in. She would then choose one of the two evidentiary chairs – either for or against – and speak from that perspective. In the schema-challenging chair: "What she is saying is false and exaggerated. I am a bit awkward, sure, but my family loves me. I do a good job with my patients, and they are grateful that I am in their lives. I am sensitive to what others are experiencing, and I strive to be a good and caring person. While it is true that I did not get a lot of love growing up, that was because the people around me had serious problems; it wasn't because of me. As I live my life, I see evidence everywhere that I am lovable."

In the schema-supporting chair: “I think she is right. I wasn’t loved when I was growing up – there must have been something wrong with me. I have so much anxiety inside of me; nothing is easy for me – nothing is easy about me. I don’t flow when I am with other people; I am always second-guessing myself.” Shari would go back and forth between these two middle chairs – making the case for each perspective as strongly as possible. Four or five rounds is a good number to start with.

Again, drawing on the work of de Oliveira (2016), we could turn the two middle chairs into a Prosecuting Attorney – who argues for the schema (‘I think the schema is right – she is awkward”) – and a Defense Attorney – who argues against the schema and who stands up for Shari (“This does not make any sense. When we look at her life, we can clearly see that people like her, care for her, and appreciate her”). Strikingly, this third person approach, in which the attorneys argue about the evidence, may be easier for the patient to do as it gives them more distance from the painful nature of the schema (Kellogg, 2014; van der Wijngaart, 2021).

After this, and with the therapist’s guidance, Shari could begin to move more freely among the four chairs. She could go back to the Healthy Adult Mode and challenge the Schema, she could then embody the Schema and make its case again, return to the two attorneys and engage in disputation, go back to the Schema and give voice to it one more time, and then end as the Healthy Adult Mode. All this moving around helps to break up the power of the schema. Again, it can also be very helpful if the therapist uses the deepening techniques and “feeds her a line” or provides her with language to speak from these different perspectives with power and emotion (Passons, 1975). After this has run its course, Shari would go back to the Healthy Adult Mode chair and reflect on what she now believes about the validity of the schema. Among the different conclusions that she might come to are:

1. “The schema was true for her in the past, but it is no longer true.
2. The schema was never true; she misperceived things based on what other people had said to her. When she looked at the evidence, it just did not stand up.
3. The schema is true. Working with the understanding that all people have weaknesses, she can do some grief processing and accept her awkwardness with compassion and look at further developing her strengths.
4. She could acknowledge that there might be some truth to the schema, and then decide to make a conscious and concerted effort to: (a) challenge the childhood origins of the schema; and (b) learn new and more effective ways of working with the schema” (Kellogg, 2022, p. 6).

Again, this *Evidentiary Dialogue* form is focused on the truth or the *validity* of the schema.

**Schema Mode Therapy – An Overview**

Over time, Schema Mode Therapy has become the more dominant model of Schema Therapy – which is directly linked to the central principle of *multiplicity of self* (Rowan, 2010). The inner world of suffering people is often filled with a diverse combination of modes (Kellogg & Garcia Torres, 2021) which may include:

1. Modes made up of pain, fear, and trauma;
2. Frustrated modes that are angry and may act impulsively;
3. Modes that are critical of and punitive with the self;
4. Modes dealing with pain and fear by disconnecting or overcompensating with grandiose or aggressive behaviors; and
5. The Healthy Adult Mode that stabilizes the system for adaptive functioning in the world (Kellogg & Young, 2006).

While each can play an important and useful role in a healthy system, they can also be quite problematic when there is an imbalance – especially when the Healthy Adult Mode is underdeveloped or very weak (Kellogg & Garcia Torres, 2021). Working with chairs not only helps to differentiate modes, but also serves to organize them into a dynamic system that is functioning at a higher level (Finogenow, 2021). Kellogg & Garcia Torres (2021) emphasized that developing the Healthy Adult mode is the ultimate goal of working with chairs; it is also a central goal of Schema Therapy (Lobbestael, 2008). This is because a strong Healthy Adult will bring emotional balance to everyone at the table. It does this by:

1. Taking care and healing the pain of the mode that suffers;
2. Finding socially acceptable ways of expressing the needs and desires of the angry and impulsive modes;
3. Containing the damaging or destructive influence of inner critic modes; and
4. Decreasing the problematic use of coping modes.

**2. Mode Interviews**

Coping modes often have a complex role in the patient's life. A first step can be to interview them to better understand their role and function in the patient's life. When used for evaluation purposes, the goal is to better understand its developmental origins ("Where do you come from?"), its intention ("What is your role in the patient's life?"), its triggers ("When do you take control?") and its motivations ("What are your fears about not playing this role?"). Interviewing the mode provides an opportunity to build a better understanding of its etiology and function (Kellogg, 2014; Kellogg & Garcia Torres, 2021). These dialogues can also drive subsequent imagery work (Pugh & Rae, 2019).

Using a *Giving Voice* dialogue structure, "Arntz and Jacob (2013) presented the case of Sabine – a patient who reported that she had a 'wall' inside. They asked her to 'become' the wall, and when they interviewed it, the 'wall,' said, in essence: 'Since I came into Sabine's life, she has had the ability to detach. I help to keep her safe.' When the therapist explored the history of the wall and why it came into Sabine's life, it responded that it first came into her life because her father would get aggressive and threaten her; it would shut everything down so that she could survive. Later, her classmates were cruel to her, so it continued to shut things down. When they affirmed how central the wall had been to Sabine's survival, the wall agreed with that assessment" (Kellogg & Garcia Torres, 2021, p. 173). In this example, they were able to better understand the development and role of a *Detached Protector Mode*.

**3. Cost-Benefit Analyses**

Coping modes develop to help the individual survive difficult situations as a child and adolescent. With adult patients, the challenge is that these modes, which were once adaptive, have now become anachronistic; they have become less adaptive or even problematic in the world that the patient is currently living in. After a *Giving Voice* dialogue with a coping mode, a *Cost-Benefit Dialogue* can be helpful as a means of assessing the current *utility* of the mode in the patient's life (Burns, 2006). This is a form of *Internal Dialogue*, and the *Rhombic Dialogue* format is, again, ideal. Arntz and Jacob (2013) described a patient named Nicole who used her *Bully-and-Attack mode* in problematic ways. The *Bully-and-Attack Mode* is a type of *Overcompensation Mode* that is based on the idea that offense is the best defense. Building on their work, a *Cost-Benefit Dialogue* could be created to explore the dynamics of this mode in her present life. The schema therapist would first sit down with Nicole and sort out the current costs and benefits, the current positives and negatives, of the *Bully-and-Attack Mode* in her life. For Nicole, the positives were: "Others respect me, as they are afraid of me" and "I can make sure that no one will abuse and hurt me." There is a great deal of power in this mode, and there is a hint of a traumatic underpinning that is fueling and energizing this part. They would then explore the downsides of this mode in its current form. These include: "Others are afraid of me; that's why they don't like me" and "I keep getting in trouble with the law; I have problems with the police" (p. 123). Here, the threats to her freedom are becoming paramount.

Setting up the four chairs, she would begin in the Healthy Adult mode with the affirmation: "I am Nicole. I am the Healthy Adult Mode, and this is my life. I have different parts. These parts have their histories. These parts have their functions. These parts are important. However, I am the Healthy Adult Mode, and it is my life; it is not their life." She would then do a role reversal and move to the chair opposite – the chair that embodies the *Bully-and-Attack Mode* – and give voice to her perspective: "I am here to keep you safe. I believe that offense is the best defense, so I want to attack others before they attack me."

In the two middle chairs, she would give voice to the positives and negatives, the costs and benefits, of the mode in her life. Again, Nicole could give voice to these as herself or take the role of two attorneys arguing the different perspectives: "I think that Nicole should let the mode keep doing what it is doing. It has kept her safe for so many years – why change now?" "She is older now and her life is changing. She is stronger now, and she does not need to be so aggressive; it is not like the old days. Also, people do not like this side of her. She is going to be an old and lonely woman if she keeps this up. She may even end up in prison." After several rounds of this, she could then move freely among the four chairs giving voice to all the different perspectives. At the end, she would then go back to Center and the Healthy Adult Mode and reflect on what she heard in the two chairs. The goal would be to form a new relationship between the Healthy Adult Mode and the coping mode. It is an important part of her as it is her defense system, *and* it needs to be less automatic and more under the control of the Healthy Adult Mode. This new way of being will likely require practice and some ongoing negotiations. This *Cost-Benefit* dialogue is focused on exploring the *utility* of the mode (see also van der Wijngaart, 2021).

**4. Mode Dialogues**

These two dialogue structures – *Mode Interviews* and *Rhombic Dialogues* – can serve as a foundation for a series of mode dialogues between the Healthy Adult Mode and the Child, Coping, and Inner Critic modes. Again, the goal is for the patient to have a Chairwork experience in which the Healthy Adult Mode is strengthened and gains increasing control over the system (Lobbestael, 2008). This is done by listening to the concerns of the mode, responding in an empowered way, and creating a new relationship with those modes that are causing difficulty. This would include:

1. Listening to the Vulnerable Child mode, expressing deep compassion for their suffering, and committing to reducing the suffering as much as possible.
2. Acknowledging the concerns and frustrations of the Angry and Impulsive Child modes, while affirming (a) that the Healthy Adult will sort them out though the use of assertive methods and (b) that these modes are not to act independently to get their needs met.
3. With the coping modes, the Healthy Adult Mode can first thank them for all that they have done to help them survive; they can then point out that their behavior and strategies – shutting down, avoiding, self-soothing, self-stimulating, attention-seeking, and/or aggression toward others – are excessive or they are no longer appropriate. Since coping modes do not go away, the goal here is to create a new relationship with them.
4. Perhaps most important of all is the work with the Inner Critic Modes – which were formerly called the Demanding Parent or Punitive Parent modes (Farrell & Shaw, 2018; Roediger, Stevens, & Brockman, 2018). Recent work by Kellogg and Garcia Torres (2021) has expanded the understanding of the nature of the Inner Critic Modes in Schema Therapy.

Traditionally, the Inner Critic Mode was thought to be an internalization of harsh, critical, and/or abusive experiences with significant others during crucial developmental periods in the patient's life (Kellogg & Young, 2006; Young et al, 2003). Given that Schema Mode Therapy has its origins in the treatment of patients with Borderline Personality Disorder – a group with high levels of trauma in their backgrounds – this perspective is not a surprise. Some patients report that they can hear or feel an abusive parent or other figure in their mind or being; this is called the *Internalized Abuser Critic*. However, the Stones, in their *Voice Dialogue* work (Stone & Stone, 1989), have made the case that the Inner Critic develops early in the life of the individual as a part that is trying to keep the child safe; in Schema Therapy terms, the Inner Critic is actually a coping mode, and this mode is called the *Protector Critic* (see also Behary & Brockman, 2023).

Building on this, it is important for the schema therapist to use the *Giving Voice* work as a kind of differential diagnostic interview to determine: (a) is the critic filled with anxiety and seeking to help the patient do better? Or (b) is the critic filled with hatred, dislike, or disdain for the patient and hopes of damaging or destroying the patient? This is important because different strategies will be utilized depending on the nature of the Inner Critic. If it is a Protector Critic, the therapist begins by setting up a *Rhombic Dialogue.* The patient can begin in Center or in the

Healthy Adult mode – with the Protector Critic in the chair opposite. Again, it is good to begin with an anchoring affirmation: "I am the Healthy Adult Mode, and this is my life!" This time the two side chairs will face the Protector Critic and speak to it directly. One of them will embody appreciations for what this Critic has done to help them in their life ("You helped me persevere and get through some very difficult times"); the other chair will embody their sense that this mode has become quite problematic ("You cause relentless stress and anxiety; there is never any peace when you are around. I think that you are stopping me from going forward in my life"). After this, the patient can move among the four chairs – embodying and expressing their different viewpoints. This can include doing a role reversal so that the Protector Critic can directly make its case for trying to keep the patient safe.

The next step is for the Healthy Adult Mode, working with the therapist, to identify and affirm their values, goals, and desires and to use these in a dialogue with the Protector Critic. Of note, in some cases, their values may be in alignment with those of the Protector Critic and in others there may be differences. What is crucial is for the person to be living a life based on chosen values (Roediger et al., 2018) rather than on "shoulds" – even if they are rooted in benign intent. The goal is to create a new relationship in which the Protector Critic and the Healthy Adult Mode can work together, in which they can form a team, to help the patient live a good life based on these values. It should be noted that there are some patients who do not wish to lead a self-directed life and would rather that the *Protector Critic* continues to tell them what to do. This leaves them with an internal world in which they remain in a kind of child state – being told what to do by an anxious, stern, or grumpy parent figure; nonetheless, this is their choice.

On the other hand, if it is an Internalized Abuser Critic, the work will be centered on the patient first understanding and accepting the reality that the critical voice within them is toxic and that its purpose is to hurt them. One powerful way to begin is to sequence directly from the Mode Interview. Once it is clear that it is an Internalized Abuser Critic, it can be very powerful for the therapist to attack this critic while the patient is still embodying that mode. The therapist should strive to be as intense as possible while consistently defending the patient (van der Wijngaart, 2021). The patient can speak as the Internalized Abuser and fight back by continuing to demean the patient. Strikingly, this can be a deeply reorienting experience for the patient as they have usually never heard anyone attack the Internalized Abuser Critic before; again, at the start, the patient may be very frightened of the critic and/or may believe the things the Internalized Abuser says, so this kind of reparenting and advocacy by the therapist will be of great importance.

The next step will involve a confrontation between the Healthy Adult Mode and the Internalized Abuser. Using the *Rhombic Dialogue* structure, in one middle chair, the patient can talk to the Internalized Abuser Critic about the pain, fear, and damage that it has caused them, and in the other, they can express their anger and rage about its impact on what the Abuser has done to them. Returning to Center and the Healthy Adult Mode, and with the help of the therapist, they can then begin the process of rejecting the Internalized Abusive Critic and choose to live a life based on their own values; it is likely to be beneficial for this dialogue to be repeated. Throughout this process, the therapist should continue to supply language and support. In addition, it will be important for the patient to continue to identify and label the Internalized Abuser's voice so that it can be recognized when it emerges; here, the labeling, observing, and distancing practices of *Contextual Schema Therapy* (Roediger et al., 2018) can be very helpful.

In addition to Chairwork dialogues between the Healthy Adult mode and the other modes, it can be quite helpful to have dialogues *among* the different modes (Finogenow, 2021). For example, the Vulnerable Child Mode can engage in a dialogue with a coping mode – they can engage with a self-soothing protector mode or a detached protector and speak of their unhappiness that they never get to express the pain that they are in (Pugh & Rae, 2019).

**5. Trauma-Centered Chairwork/Three-Person Storytelling**

The next two dialogue structures develop from the reality that Schema Therapy is, fundamentally, a trauma-centered psychotherapy. The first of these is *Three-Person Storytelling* (Roediger et al., 2018), which is a manifestation of the *Telling the Story* dialogue structure. The purpose is to engage with and work through difficult or traumatic memories. As a form of exposure work, the patient can be invited to move to another chair and tell a difficult story or memory – saying as much or as little as they wish. They are then encouraged to get up, move around, shake it off, and then sit down and do it again. The therapist and patient should strive to do this four or five times – but the comfort and willingness of the patient is the ultimate arbiter of what will be done. In the original formulation (Kellogg, 2018), the patient was invited to do this in the first person. For example, a patient named Harper would be asked to tell the trauma story or memory from the "I" perspective: "I was in a car accident, and these are some of the things that happened to me." Adapting an idea from *Contextual Schema Therapy*, they would be encouraged to use the third person voice instead – at least to start. This means that a patient named Harper would go to another chair and speak about themself in the third person: "Harper was in a car accident, and these are some of the things that happened to them." The value of the third-person voice is that it gives the patient some distance from the trauma while allowing for sufficient emotional arousal to be therapeutically effective.

As patients do this form of Chairwork, more details usually begin to emerge – which is a sign that the trauma is being integrated. Another positive is that the therapist, through the process of witnessing and working with the different iterations of the trauma story, begins to habituate to the narrative which means that they will feel more comfortable with it and have greater freedom when working with the patient.

**6. Trauma-Centered Chairwork/Confrontation Dialogues**

*Confrontation Dialogues* is another Chairwork form that schema therapists will want to know and master. Imagery Rescripting (Simpson & Arntz, 2020) is a fundamental method for uncovering and working through interpersonal mistreatment and abuse – especially that which takes place in early childhood. Chairwork can build on this in two ways: (1) it can serve to deepen and intensify the encounters that took place in the imagery work; and (2) since some patients do not want to close their eyes in the presence of the therapist, Chairwork can be an alternative method for working through these traumas.

Using the *Relationships and Encounters* dialogue structure, the therapist can utilize a dialogue structure that is drawn from the Gouldings' (1997) *Redecision Therapy* model. To begin, the patient sits in one chair, and they imagine the abuser or the perpetrator in the chair opposite[iv]. In the first step, the patient tells the person who hurt them exactly what they did to them. The goal is to recount the wrongdoing with as much detail as possible. The second step is

to tell them what the immediate impact was: “I felt tainted.” “I felt like something had been taken from me.” “I had the burden of a secret.” “I was terrified.” The third step is to tell them the long-term impact of the mistreatment: “Since then, I have been chronically depressed.” “I cut myself.” “I get high all the time.” “I do not trust anyone.” “I have had no self-esteem.” The final steps are forms of *existential empowerment* (Kellogg, 2014). They involve the patient deciding to no longer live in the shadow of the mistreatment, and to now claim a new way of living that is in clear defiance of the mistreatment. The Gouldings (1997) give examples from three women who went through this process: “From now on, I am going to find trustworthy people, and I will trust them. Everyone is not like you.” “I enjoy sex today in spite of what you did to me. You are no longer in my bed.” “I can laugh and jump and dance without guilt, because my fun didn’t cause you to rape me! It was your perversity!” (p. 248).

**7. Relational Self Dialogues**

Dialogues can also take place with the patient’s self or different parts of the patient’s self at different points in their life span. That is, they can have an encounter with themselves as a child, adolescent, person in their thirties, and as an elder. They can also speak to a specific part of themselves at different points in the life cycle. This *Relational Self Dialogue* model is drawn directly Dayton’s *Attachment Timeline* (2023) and *Life Cycle Role Reversal* (1994), and it combines aspects of *Relationships and Encounters* and *Internal Dialogues*. This allows the patient to work with traumatic experiences that they experienced at any time in their life – including as children.

Working with mistreatment as a child, the patient starts in Center – in the Healthy Adult Mode. They imagine themselves as a child in the chair opposite, and they begin by expressing – to the child – the anger, distress, and grief they feel about what their younger self went through. They then do a role reversal and switch chairs and “become” this child. The child is then invited to speak from their experience and perspective. The child can speak about what they went through and how they are feeling about it – to whatever degree they are willing and able to. The patient can move back and forth between being the adult self and the young child self. At some point, the therapist can begin to ask the child if they are able to hear what their adult self is saying and whether they are able to take it in. If they are, that is good; if not, it is important to ask them why and to clarify what the impediment is (Brouillette, 2023).

There are two strategies to keep in mind. First, it is important to emphasize to the child that they are seen, that their story has been heard, and that they are not alone. Telling them that everything will be alright is not a good idea as that may not be the case, and the child may not believe them. Second, it is important that an emotional connection is made with the child. This can include affirmations of the goodness and beauty of the child and the expression of deep distress by the adult self as to what the child has been going through. This may be quite difficult for some patients as they do not like the abused or traumatized child that they were. Here the therapist can step in and speak from their distress: “I see you and I see what you have been through, I am so distressed by it. This never should have happened to you – this is so wrong. You did not deserve any of this. You did not deserve any of this – it is all their fault. You are such a beautiful and lovely child. That is the real truth here.” Again, this is a form of *reparenting* (Rafaeli et al., 2011). When this dialogue is completed, the traumatized child chair can be moved to the side, and the patient and the therapist can debrief the experience.

**8. Working with the Therapeutic Impasse: "Floating Above"**

One of the great gifts of Schema Therapy is its deep commitment to patients who have deep personality struggles and/or complex and rigid mode structures. Given that, it is to be expected that therapeutic ruptures and impasses will be a part of the therapeutic journey and the healing process (Rafaeli et al., 2011; Safran & Kraus, 2015). When this occurs, Roediger and colleagues' "Floating Above" technique can be quite useful (Roediger et al., 2018). Here, both the therapist and the patient stand up and imagine themselves sitting in the chairs below. They can then reflect on what each one is failing to understand about the other. This is a way to not only decrease the emotional intensity, but also increase the presence of the Healthy Adult Mode in both the patient and the therapist. The goal of this kind of dialogue work is for the two of them to be able to form a team and work together to discover strategies for moving forward.

## Conclusion

Schema Therapy is a very effective form of psychotherapy; Chairwork, in turn, contributes to the healing power of Schema Therapy in three ways. First, it helps to clearly delineate the parts or the modes by externalizing and personifying the forces that are active within the person. Second, through the dimension of space, it facilitates encounters between and among the different modes. Third, it activates neurobiological arousal which facilitates cognitive restructuring and schema transformation (Kellogg, 2023; Pugh, 2019; Samoilov & Goldfried, 2000; Young et al., 2003). When used in concert, they create a compelling form of treatment that can help, and, hopefully, liberate those who are living in deep emotional and psychological pain and anguish.

Endnotes

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iii. Our thanks to Amanda Garcia Torres for her helpful comments and her support.

iv. When doing this kind of trauma work, it is important that the patient does not do a role-reversal and play the role of the abuser. This can seriously handicap them in their ability to freely express the anger, pain, fear, and grief that they may be experiencing in relationship to these experiences.

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