CLIENTS FOR WHOM THE TECHNIQUE IS APPROPRIATE

Adults and adolescents burdened with “unfinished business” with the deceased, whether in terms of intense separation distress, anger, guilt or other issues, or who simply want to reorganize an ongoing bond with them of a more fluid and accessible kind. Facilitated dialogues using chair work may be contraindicated for clients who struggle with intense traumatic distress, who are unable to suspend disbelief to engage in an imaginal conversation, or who hold religious beliefs that preclude symbolic conversations with the dead.

DESCRIPTION

Like correspondence with the deceased, chair work and other forms of imaginal dialogue have as their goal reanimating the relationship between the client and the lost figure, either to affirm lasting love and enhance secure attachment, or to address specific difficulties in the relationship (e.g., express disappointment, establish boundaries, extend forgiveness). Importantly, I rarely assume that the goal of imaginal dialogue with the deceased is to “say goodbye,” in the sense of “seeking closure” or “withdrawing emotional energy” from the deceased in order to invest it elsewhere, a practice that nonetheless may be appropriate when the living relationship with the deceased was marked by oppression or abuse, making a kind of “divorce” or separation in death the better outcome. Far more commonly, the goal is to renegotiate the relationship as a living resource for the client and therapist to access in their mutual work, and typically for the client to draw upon in the form of affirmative and clarifying inner conversations beyond the bounds of therapy.

My practice of chair work is influenced both by the rich tradition of emotion-focused therapy (Greenberg, 2010) and dialogical self theory (Rowan, 2010), which add usefully to more basic imaginal procedures for facilitating symbolic encounters or conversations with the deceased through the use of positioning and choreography to augment a verbalized or imagined exchange. As I use the terms, positioning refers to the projection of the deceased (or relevant others, or aspects of the self) into the various chairs, whereas choreography refers to the artful sequencing of steps in the encounter, which commonly involves movement of the client (and sometimes the therapist) among the chairs, both in the active stages of the encounter and during subsequent processing. Here I will offer a personal distillation of
procedures I find useful in the context of grief therapy, referring the reader to the more ample presentation of related techniques in the references below.

1. Setting the stage: Chairing is a very flexible technique that can be performed with minimal prompts—in the limiting case, two simple chairs that can be placed face to face, the client seated in one, the deceased symbolically placed in the other. In a small office with only two chairs, the therapist can offer his or hers to the client, crouching or kneeling at right angles to two seats so as to be less imposing and intrusive during the facilitated dialogue. Alternatively, a third chair can be brought in and “offered” to the deceased directly across from the client, with the therapist retaining his or her original seat. However, my preferred staging using four chairs as the corners of a “square” is pictured in Figure 69.1 and diagrammed in Figure 69.2, which also adds notation suggesting the choreography of the session, as described below. This permits maximum flexibility in assignment of positions, and representing a default arrangement for therapy, permits fluid shifting into and out of chair work without rearrangement of furniture.

2. Initiating chair work: Chairing can be planned, as when a client fearful of confrontation with the deceased is prepared through previous discussion with the therapist or through homework to consider what needs to be voiced in an encounter to follow. More commonly, however, I find that a client’s readiness for the technique is suggested by spontaneous comments such as, “I just want to say to him that . . . ,” “She’d understand if she were here,” or other indications of need to address the deceased, or hear from him or her directly. In such cases, without an elaborate preamble, I typically gesture toward the empty chair opposite the client, if our initial juxtaposition to one another reflects the positioning in Figure 69.2, and simply say something like, “What would you say to _______ now about that, if she were seated right here with us, and could hear you?” If the client initially is positioned opposite me, I will commonly gesture to the empty chair to my right, with the simple invitation, “Why don’t you come over here for a moment . . . ?,” and then extend encouragement to address the deceased in the empty chair opposite, as above. I keep instructions minimal, and do the briefest of acceptance checks on the client’s readiness to engage in the imaginal dialogue (e.g., “I wonder if you would be willing to say that, right now, to him?”), indicating the empty chair with a slow wave of the hand. In my experience, elaborate prologues and stilted descriptions of the procedure heighten the client’s apprehension and deaden the subsequent interaction, bleaching it of spontaneity.

3. Prompting for honesty and directness: As the client begins to speak, I redirect my eyes to the empty chair, slightly pivoting in its direction, to reinforce the reality of the encounter and to discourage continued eye contact with me, as I direct the client to

* In my basic four-chair configuration, I find that 60% of the time, when I take a chair or “mark” my positioning by leaving a clipboard on the seat, my client will from the first session on take a chair at right angles to my own, typically to my right. Such a position approximates common “living room” conversational positioning, offering the prospect of easy eye contact at a 45-degree angle without it being obligatory, or without visual disengagement by the client seeming defensive, as a gaze that wanders forward would feel natural. Some 30% of the time, however, the client will take the seat directly opposite mine, perhaps signaling greater readiness for direct encounter with high levels of eye contact being the norm. My usual practice is to allow clients discretion regarding initial positioning to enhance their comfort or to construct the relationship with me for which they are ready, and then reposition them as our work requires. This is not the space for a detailed discussion of proxemic factors in therapy, however, beyond those necessary for the present discussion of chairing.
the “deceased” with my gaze. Once the dialogue is established, however, I will reorient to the client periodically to follow his or her nonverbal gestures and expressions, as well as to affirm and underscore his or her statements with a head nod or facial signal. I encourage the client’s use of first-person “I” language through the use of an incomplete statement relevant to the therapeutic task: “What I need you to know is . . .” or “Tell him about how you are doing now, and what you need from him now. Maybe start by saying, ‘Dad, the truth is that I . . .’” If the client slips into third-person language (e.g., “I guess I’d tell him that . . .”), I simply quietly model, “What I want to tell you is . . .”, and then redirect my gaze to the empty chair. I tag and underscore statements of feeling, and other language that intensifies the connection: “Tell her more about that ‘black hole’ you feel,” or “What more can you say about what you still need from him, now?”

4. Choreographing the exchange: At a resonant moment of the exchange, when the client has voiced something poignant that calls for the response of the other—much as it might if voiced in a family therapy session—I meet his or her eyes, gesture toward the opposite chair and say something like, “I wonder if you could come over here now . . .”, and as the client does so, continue, “. . . and now, just listen ______ your own voice, what would you say back to [your daughter/your mother, etc.] as she says to you, ‘I’ll never forgive myself for not being there to protect you . . . you were always there for me . . . and I let you down when you needed me most’ [paraphrasing the client briefly]? What do you want to say to her about that?” I then redirect my gaze to the client’s original seat and await the reply, again shaping toward honesty, immediacy, and depth. Once more, typically after a few minutes, I listen for a poignant expression, watch for the
emergence of strong emotion, wait for a pregnant pause, and then, just as I would in any other couples or family session, redirect the client to his or her original seat and invite a response. I continue to orchestrate the interaction in this way to a point of natural completion of the exchange or until the client meets with an insuperable impasse or meets my eyes with an obvious need to process that which has emerged, which might typically range from 5 to 15 minutes of interaction between the two positions.

5. **Shifting into processing**: During the imaginal conversation I work consistently to minimize slippage into commentary (e.g., “I don’t know if he’d want to hear that, because . . .”) by interrupting tactfully and reframing the statement into dialogue (e.g., “I don’t know if you really want to hear this, but . . .”) to retain the strongly experiential quality of the work, within which nearly all change occurs. However, once novel material has emerged and a given episode of dialogue concluded, commentary is frequently essential to harvest its implications. To foster this, I commonly invite the client to shift to a third “witness” chair (see Figure 69.2), and say something like, “I imagine that a part of you was listening in to the dialogue that just unfolded here. . . . What caught your attention about the relationship between the two of them, or what did you observe that seemed important?” Although in canonical emotion-focused therapy clients are simply directed back to their original chair for the purposes of such processing, the fact that they are back in their familiar position, oriented inadvertently toward the seat occupied by the
“deceased,” discourages self-observation, and tends to concentrate unduly on observations about the other (e.g., “He didn’t seem to be really listening to me”). In contrast, when offered the “meta-position” of the witness chair, the client is more likely to grasp features of the relationship (e.g., “I can’t believe how much it still sounds like it did when I was a little girl”) or to share observations about the self (e.g., “I really seemed to have a hard time standing up to her”). I follow the client’s lead in making interpretations, sometimes volunteering an observation and inviting the client’s sense of it (e.g., “Did you notice his tone of voice when he said ______? What did you make of that?”). Ultimately, we shift back into our original positions to bring the session to a close, or to pursue another line of work.

Variations

The schematic outline above invites many elaborations. Here I will note only a few of these briefly, deferring to written or videotaped extensions of this work to provide more ample illustrations than a brief chapter permits (Neimeyer, 2004; Neimeyer, Burke, Mackay, & Stringer, 2010).

1. Voicing nonverbal meanings: In the course of the imaginal conversation, the therapist can note significant gestures, expressions or bodily positions, and ask the client to voice these into the dialogue without further commentary or interpretation (e.g., “What are you doing with your hands right now? Can you do that again, more forcefully? What are you trying to do there?” “Just reach him, I guess.” “Could you say that to him directly, ‘I’m really trying to reach you, to get through to you?’”). The dialogue then continues with this new communication taken into account.

2. Moving into alignment: As depicted in Figure 69.2, the therapist can signal greater support for a client during a difficult exchange by shifting position to kneel or crouch beside him or her, looking at the deceased, and continuing as before (e.g., “Could you tell him that again, even more strongly . . . ‘Dad, you just weren’t there for me!’”). Still stronger support, as in the context of “unfinished business” deriving from emotional, physical or sexual abuse of the client by the deceased, can be signaled by the therapist’s literally standing alongside the seated client while prompting the client toward a position of strength (e.g., “Try telling him, ‘You can never hurt me again.’”). I find that the more acute the angle between the client and therapist, the more intense is his or her sense of being supported by my positioning. However, I rarely align with the deceased in this way, as it can easily be experienced as a “two-on-one” joining against the client, who is thereby triangulated out.

3. Interviewing the deceased: Inviting the client to role play the deceased, the therapist can interview him or her about the client’s strengths, needs, and special qualities, or about particular concerns in the relationship, after first learning from the client how it would be appropriate to address him or her (e.g., “Sarah, I’ve been talking to your daughter Rebecca here for the past few weeks, and she’s a little concerned that if she moves to another city other than this one that she has always shared with you, she’ll be abandoning you in some way. What do you think of that?” or “Mr. Davis, what do you consider your son’s special qualities as man, the things you were most proud of in him? What fatherly advice would you give him now?”). This often allows the client to access voice of the internalized other, with the therapist asking questions that client might not, to healing effect.

4. Dialoguing with other parts of the self: Rather than have an imaginal dialogue with the deceased, the client could usefully engage another aspect of the self (e.g., this
frightened little girl in her), a source of wise counsel (e.g., God or the self as spiritual seeker), or even his or her symptomatology (e.g., having a dialogue with his personified “grief” or “suffering,” staying close to the client’s own language, to learn more about its role and purposes in his or her life).

5. **Doubling for the client:** From the “support” position standing close alongside the client, the therapist can gently ask permission to touch the client’s shoulder in the course of an imaginal dialogue, noting briefly that in doing so, he or she will “stand in” for the client for a single conversational turn. This allows the therapist to articulate an implicit feeling or need hinted at, but not fully voiced by the client (e.g., “*When I place my hand on your shoulder, let me offer something, just to see if it feels emotionally true to you. If it does, then when I take my hand away, you can continue, just as if you had said that.*”). If the therapist is attuned to the client’s affective meanings, this can be a powerful way of prompting the interaction toward greater depth and clarity (e.g., “The truth is, Mom, I’m still trying to win your love.”). As in nearly all therapy, the power of the statement is inversely correlated with its length.

6. **Using the empty chair:** Instead of rotating the client to the empty chair to speak on behalf of the other, the therapist can simply prompt a monological voicing of the client’s position vis-à-vis the other (e.g., “*What do you need to tell her about that? Can you say that to her, now?*”). Not repositioning the client into the chair of the other can effectively silence that position, which may be appropriate in cases of oppression or abuse, allowing the client to speak his or her truth without broaching contradiction or retribution.

The following case briefly illustrates some of these procedures.

**CASE EXAMPLE**

Maria, at 45, sought therapy for a longstanding low-grade depression that had characterized much of her adult life. Though she had been reasonably successful in her career as a nutritionist, she felt unfulfilled, lonely, and vulnerable to feeling “left out” of social arrangements, leading her to retreat into a private world filled with books and solitary walks. Though married from the age of 20 to Tony and reportedly having experienced little conflict with him, their somewhat “roommate-like” relationship did little to mitigate her sense of aloneness in the world, even if it was hard for her to say what needed to change.

As we explored the origins of her chronic susceptibility to sadness (which had proven unresponsive to several attempts at pharmacotherapy and marriage counseling), we found that it dated from a difficult time in her early twenties, when she miscarried an unplanned pregnancy, and shortly thereafter chose to terminate a second pregnancy because, Maria said, she and Tony “were not ready to be parents.” Asking if she knew the sex of the child, I watched her eyes fill with tears as she said she was “a baby girl.” Seeing her obvious emotional investment in the baby, I gently asked if she had given her a name. “Olivia,” she whispered, voicing her daughter’s name for the first time in over 20 years. It soon became clear that much of what she had experienced as depression was better understood as grief tinged with regret and guilt about the fateful decision that left her childless, with much to be said about and to the child who she and Tony chose not to bring into the world and into their home. Wondering aloud if this were the case, I saw her nod slowly and sadly, opening the prospect of an imaginal conversation in the place of the one that had never taken place.

Standing, I collected a lap blanket thrown over the arm of one chair, and rolled it into a small bundle, laying it gingerly on a cushion in the empty chair opposite Maria to represent Olivia. “What might you say to her now,” I asked, “if she could hear and understand what she could not
at that difficult time?” Quietly, looking down, Maria replied that she felt like the child, helpless and unprepared, and then fell silent for several seconds. Lifting her right hand to her throat, she noted, “I feel very...constricted about it...I was so idealistic about being a parent, so afraid of the responsibility...It was easier to let Tony make the decision, and I just went along with it. But I’ve had to live with it ever since.” Prompting her toward still greater depth, I offered, “I have had to live with this decision, rather than with you.” Maria, weeping openly now, modified this and stated to Olivia, “I have had to live with this decision...I would rather have lived with you.”

Continuing, I asked her to tell her daughter what she would have wanted for her. “Two loving parents,” was her reply, “who were not afraid of you. I was afraid I would not be what you needed...But I still loved you.” “I do love you,” I offered in the present tense. Maria repeated this movingly, then hesitated, and added, “What comes to me is that it should have been enough...but I had my own needs.” Encouraging her to voice these, I listened as she spoke to her daughter about her own need for “support, and for enough commitment in the marriage relationship.” But Tony, she said, “had one foot out the door always...and I do the same thing.”

Looking directly into my eyes, she broke the frame of imaginal dialogue, and remarked, nodding sadly, “It wouldn’t have worked for either of us to have someone too needy or clingy.” “Like Olivia,” I suggested. Nodding, Maria added, “or each other.”

Moving to the witness chair to process the experience, Maria connected her decision at age 22 to her own experience as a child of a “dad who was irresponsible in all roles,” leaving her to be raised by a single mother who was woefully inadequate to the task. She immediately flashed to Tony’s critical absence on work-related travel when she miscarried the first child, and the way in which “he had never connected to [her] losses, but was just absent to it all.” Maria at 22, she noted, “carried around a lot of anger about that, and it came out as distance, which he enjoyed.” “So even in your distance,” I noted, “you gave him what he wanted.” Furrowing her brow, Maria added, “and what I want.” We went on to discuss her stance of self-protection from further abandonment, cultivated across a lifetime, purchased at the price of great emptiness. Further chair work between Maria at 45 and Maria at 22 followed, leading to deepened self-compassion, and a joint resolve to face their shared grief over their losses, and to “look for an opening” to greater intimacy in relationships in general, and her marriage in particular.

CONCLUDING THOUGHTS

As a vividly experiential intervention that invites immediacy and vulnerability with the deceased, with the therapist, and with the client’s self, chair work requires a sense of discernment on the part of an experienced therapist, as well as some delicacy in guiding the imaginal dialogue toward a more satisfying resolution. Because it is typically emotionally intense, it should be used only once a strong therapeutic alliance is in place and the client has demonstrated an ability to engage in adaptive emotional modulation and meaning making in relation to other material. Imaginal dialogues play a central role in demonstrably effective therapy for complicated grief, as assessed in a randomized controlled trial (Shear, Frank, Houch, & Reynolds, 2005), and fit broadly with a dialogical theory of self that carries rich practical implications for grief therapy (Neimeyer, 2011). With sufficient training and attunement on the part of the therapist, and courage and openness on the part of the client, chair work can promote healing conversations with the self and deceased that transcend even the silence of the grave.

References


