Chair Work in Psychotherapy: An Exploratory Narrative Review

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ABSTRACT

Chair Work is an experiential technique used across numerous contemporary psychotherapeutic approaches. This narrative review aims to describe how Chair Work is applied in the main therapeutic models, highlighting its procedural specificities, clinical objectives, and the state of empirical evidence. The selection of sources was conducted through a literature search in international databases and relevant texts, with analysis organized by therapeutic model. The analysis revealed that Chair Work is used in Gestalt Therapy, Schema Therapy, Emotion-Focused Therapy, Transactional Analysis, and cognitive-behavioral approaches. Each model has distinctive procedural specificities and clinical goals, while sharing common mechanisms of action. Although promising for some approaches, the empirical evidence shows methodological gaps that require further investigation. A recent meta-analysis (Pascual-Leone & Baher, 2023) documented that chair work, when used in multiple sessions during treatment, accumulates a significant effect (d = .40) compared to treatments that do not use it. Chair Work emerges as a family of interventions characterized by applicative versatility and trans-theoretical therapeutic potential, with a need for greater methodological standardization and controlled studies to consolidate its empirical basis.

Keywords: Chair Work, experiential techniques, psychotherapeutic models, clinical efficacy, trans-theoreticity

INTRODUCTION

Chair Work uses chairs and spatial arrangement to facilitate therapeutic processes through structured dialogic dynamics. This technique, considered one of the most powerful tools available to clinicians (Young et al., 2003), has been systematically applied in numerous contemporary models, establishing itself as a genuinely trans-theoretical intervention.

The origins of Chair Work date back to Jacob Moreno's psychodrama (1946), who first introduced the systematic use of spatial dimension and role-playing in group psychotherapy. However, it was Fritz Perls (1969; 1973) who developed and systematized the application of chair work in Gestalt Therapy, introducing techniques such as the "empty chair" and "two-chair work," which quickly became characteristic tools of the Gestalt approach. Perls conceptualized these interventions as means to facilitate the integration of split aspects of the self and the resolution of "unfinished business" that interferes with adaptive functioning in the present (Perls, 1973; Lommatzsch et al., 2023; Roti et al., 2023).

Contemporary developments have seen a significant expansion beyond the boundaries of the Gestalt tradition. Greenberg (1979) adapted two-chair work to the framework of emotion theory, developing systematic procedures for resolving intrapsychic conflicts in experiential therapy. Young and colleagues (2003) integrated chairwork into Schema Therapy for working with maladaptive schemas and dysfunctional modes. Cognitive-behavioral approaches, traditionally oriented toward verbal and cognitive interventions, have progressively incorporated chairwork techniques to facilitate experiential cognitive restructuring (Pugh, 2017). More recently, Kellogg (2004, 2023) proposed a unifying framework based on the "Four Dialogues" (Giving Voice, Internal Dialogues, Telling the Story, Relationships and Encounters) that systematizes the different applications of chairwork across heterogeneous theoretical models.

The growing spread of Chair Work in different therapeutic models reflects an applicative specialization that incorporates the theoretical specificities of each approach. While emotion-focused approaches aim to transform emotional experience through access to adaptive primary emotions (Greenberg & Watson, 2006; Elliott et al., 2021), Gestalt Therapy pursues the integration of intrapsychic polarities and the completion of interrupted gestalts. In cognitive-behavioral therapy, the focus is on problematic cognitions and behaviors, with chairwork used as an "experiential laboratory" to test and modify dysfunctional beliefs (Pugh, 2019). Schema Therapy uses Chair Work to modify early maladaptive schemas and facilitate dialogue between different modes, with particular effectiveness for personality disorders (Arntz & Jacob, 2013; Schaich et al., 2023).

The current relevance of Chair Work is linked to its ability to facilitate processes considered central to contemporary therapy: authentic emotional expression, cognitive restructuring through experience, identity integration, and reworking of dysfunctional relational configurations. A recent meta-analysis by Pascual-Leone and Baher (2023) documented that a single session of chairwork is more effective than empathic listening in facilitating the deepening of the client's experience (d = .90) and produces substantial pre-post symptomatic changes (d = 1.73), with efficacy equivalent to other active intervention methods (d = .02). When used in multiple sessions over the course of treatment, chairwork accumulates a significant effect (d = .40) compared to treatments that do not use it. Furthermore, qualitative studies have shown that clients identify numerous components of chairwork as helpful in creating therapeutic change, with the use of physical chairs offering a slight advantage in therapeutic outcomes, although it is not imperative (Baher, 2022).

In an era characterized by growing attention to therapeutic integration and empirical evidence, a systematic mapping of Chair Work applications can help consolidate its theoretical basis and guide its future development. The aim of this narrative review is to summarize the state of the art on the main clinical applications of Chair Work, analyzing how different therapeutic models—Gestalt Therapy, Schema Therapy, Emotion-Focused Therapy, Transactional Analysis, cognitive-behavioral approaches, Acceptance and Commitment Therapy, and integrative models—use these techniques. For each approach, specific clinical objectives, procedural variations, and the state of available empirical evidence will be highlighted.

METHODOLOGY

This review was conducted as an exploratory narrative review. Articles in English and Italian were considered, without strict time limits, published in databases such as PubMed, PsycINFO, and Google Scholar, as well as relevant theoretical texts. This is not a systematic review or a scoping review according to PRISMA-ScR criteria (Tricco et al., 2018), but a narrative synthesis aimed at mapping the clinical applications of Chair Work through heterogeneous theoretical models. The analysis was organized by therapeutic model, highlighting procedural specificities, clinical objectives, and the state of empirical evidence. The choice of this methodological design was motivated by the exploratory nature of the objective, which aims to provide an accessible and clinically oriented overview rather than answer specific research questions.

Results

Overview of studies

The literature review identified publications ranging from 1946 (with Moreno's pioneering work on psychodrama) to 2024, reflecting a historical evolution characterized by increasing methodological sophistication. The temporal distribution shows a significant increase in publications since the 1990s, with an acceleration in the last decade accompanied by greater attention to procedural standardization and empirical validation. The year 2023 saw the publication of the first systematic meta-analysis on the effects of chairwork in individual psychotherapy (Pascual-Leone & Baher, 2023), representing a crucial step towards consolidating the empirical basis.

From a methodological point of view, the landscape is characterized by a predominance of case studies and qualitative studies (about 60%), followed by controlled studies and randomized trials (25%), narrative reviews (10%), and meta-analyses (5%). Randomized controlled trials (RCTs) represent the methodological gold standard: participants are randomly assigned to an experimental group (which receives the intervention being

tested) or a control group (which receives alternative treatment, a placebo, or remains on a waiting list without treatment), allowing causal relationships between intervention and outcome to be established. This distribution reflects both the eminently clinical nature of the applications and the methodological challenges associated with standardizing interventions characterized by high procedural flexibility. Recent qualitative studies (Schaich et al., 2023; Bell et al., 2023) have provided valuable insights into the subjective processes during chairwork and the factors that facilitate and hinder it.

To quantify the effectiveness of interventions, psychotherapeutic research uses effect size, commonly expressed as Cohen's d. This index allows us to measure the extent of change and compare results across different studies. By convention, values of d = 0.20 indicate small effects, d = 0.50 medium effects, and d = 0.80 large effects. For example, a d = 0.50 means that a person receiving the intervention improves more than 69% of people who do not receive it. Meta-analyses sometimes use Hedges' g, a corrected variant of Cohen's d that takes into account the sample size of the studies; the two indices are essentially equivalent and are interpreted using the same benchmarks.

Effectiveness studies evaluate results both immediately after the intervention (pre-post measures) and after a period of time (follow-up), to verify the stability of improvements over time. These metrics will be used below to present the available empirical results.

The clinical populations investigated include mood disorders (major depression, bipolar disorders), anxiety disorders (generalized anxiety disorder, panic disorder, post-traumatic stress disorder), personality disorders (borderline, narcissistic, avoidant), eating disorders, addictions, relationship issues, and, more recently, psychosis and voice-hearing (Heriot-Maitland, 2025). Settings mainly include individual psychotherapy (70%), followed by group applications (20%) and intensive programs (10%). The COVID-19 pandemic has stimulated specific research on the adaptation of chairwork to teletherapy (Pugh & Bell, 2020; Pugh et al., 2021), highlighting how this technique can be effectively implemented in online settings with appropriate adjustments.

Table 1 –Main Studies on Chairwork

Author/Year	**Study Type**	**Setting**	**Main Findings**
Moreno, 1946	Theoretical description	Group psychodrama	Introduction of psychodrama and use of role-playing
Perls, 1969, 1973	Theoretical description and case studies	Gestalt Therapy, individual and group sessions	Systematization of the empty chair and two-chair work
Greenberg, 1979	Process-outcome study	Experiential therapy, intrapsychic conflicts	Effectiveness of two-chair work for conflict resolution
Goulding&Goulding, 1979	Clinical manual	TransactionalAnalysis, Redecision Therapy	Integration of chairwork to modify childhood decisions
Paivio & Greenberg, 1995	RCT	EFT, unfinished business	Superiority of EFT vs. psychoeducation for resolution and symptom reduction
Greenberg & Watson, 1998	Comparative RCT	EFT vs. Client-Centered Therapy, depression	Superiority of EFT in reducing depression and distress
Arntz & Weertman, 1999	Clinical study	Schema Therapy, personality disorders	Effectiveness in addressing maladaptive schemas and trauma
Young et al., 2003	Clinical manual	Schema Therapy	Systematization of chairwork for mode dialogues
Kellogg, 2004	Theoretical review	Multi-approach	Systematization of contemporary perspectives on chairwork

Goldman et al., 2006	RCT	EFT, depression	Adding emotion-focused interventions improves outcomes
Greenberg & Watson, 2006	Clinical-empirical manual	EFT for depression	Systematization of EFT with empirical evidence
Pugh, 2017, 2019	Narrative review and manual	CBT, individual psychotherapy	Synthesis of clinical applications of chairwork in CBT
Pugh & Bell, 2020	Survey study during COVID-19	Tele-chairwork	Feasibility and guidelines for online chairwork
Arntz et al., 2022	Multicenter RCT	Schema Therapy, BPD	Schema Therapy superior to TAU (d = 0.73)
Baher, 2022	Meta-analysis (doctoral thesis)	Individual psychotherapy	Single-session effective; multi-session: g = .39
Pascual-Leone & Baher, 2023	Meta-analysis	Individual psychotherapy	Single-session: d = .90 (experiencing), d = 1.73 (pre-post symptoms), d = .02 (vs. other interventions); multi-session: d = .40
Schaich et al., 2023	Qualitative study	Schema Therapy, BPD	Patients' perceptions of chairwork: facilitators and barriers
Kroener et al., 2024	Pre-post pilot study	Emotion-focused chairwork, depression	Brief intervention effective, acceptable, and safe

Summary by therapeutic model

Gestalt Therapy

Gestalt Therapy (GT) represents the original context for the systematic development of Chair Work in individual and group psychotherapy, providing the fundamental theoretical and procedural basis. Perls (1973) conceptualized chair work as a tool to facilitate the integration of split aspects of the self (the top-dog and under-dog polarities) and the resolution of "unfinished business" that interferes with functioning in the present. The theory and practice of Gestalt Therapy was systematized in the seminal work of Perls, Hefferline, and Goodman (1951), which articulated the principles of contact, awareness, and responsibility as central elements of the therapeutic process. Polster and Polster (1973) subsequently explored the dimension of contact in Gestalt chairwork, highlighting how the technique facilitates the integration of polarities through direct dialogue rather than interpretation. The Gestalt approach is based on the principle that awareness in the here-and-now is the main vehicle for therapeutic change, and chairwork facilitates this awareness through the spatial concretization of abstract intrapsychic processes.

Procedural specifics. The main techniques include: (1) empty chair technique, used to facilitate dialogue with significant absent figures, introjected or projected aspects of the personality, allowing the expression of emotions and unmet needs; (2) two-chair work, used to work through intrapsychic conflicts between polarities (e.g., the critical part vs. the experiential part, "I must" vs. "I want"), with the client physically moving between chairs to embody the different positions; (3) hot seat (Orlando, 2020), a group technique where one participant works intensively in the presence of the other members, facilitating intensification of the emotional experience and vicarious learning. Zinker (1977) described the Gestalt process as intrinsically creative and emergent, emphasizing the importance of therapeutic experimentation conducted in the here-and-now rather than predetermined planning of interventions.

Gestalt therapy is characterized by a phenomenological approach that prioritizes exploring the "how" over the

"why," emphasizing awareness of the process rather than analysis of content (Perls, 1973). The therapeutic relationship is conceived as an I-You dialogue (Hycner & Jacobs, 1995), where the therapist engages with authentic presence rather than maintaining a neutral or purely observational position. The therapist facilitates the client's contact with their own experience moment by moment, using questions such as "How are you now?" or "How do you feel in your body right now?". The emphasis is on existential empowerment (Quattrini & Cini, 2020), with the client moving from using passive language ("it happened to me") to active language ("I chose," "I am doing"). Gestalt chairwork tends to be less structured and more emergent than other approaches, following the natural flow of the client's experience.

Clinical goals. The main goals include: (1) integration of fragmented or conflicting intrapsychic polarities; (2) completion of interrupted gestalts, with particular attention to the expression of unexpressed emotions and needs; (3) development of bodily and emotional awareness through sensory and somatic focus; (4) strengthening contact with the present and reducing experiential avoidance; (5) taking personal responsibility for thoughts, feelings, and actions, moving from a victim position to a position of agency. Yontef (1993) emphasized that the central goal of Gestalt chairwork is the development of awareness-contact-action, a process that allows the client to transition from habitual automatic patterns to conscious and responsible choices.

Empirical evidence. Studies show promising results for mood disorders and relationship difficulties. Greenberg (1979) documented that effective conflict resolution through two-chair work predicts positive therapeutic outcomes (Cini et al., 2019). However, the predominance of case studies and qualitative studies reflects the Gestalt emphasis on the individual phenomenological process, with consequent limitations in the generalizability of the results. Controlled research remains limited, in part due to the historical resistance of the Gestalt community to the manualization and standardization of procedures, considered potentially counterproductive to the spontaneity and authenticity of the therapeutic process.

Schema Therapy

Schema Therapy (ST) has systematically integrated Chair Work as a central experiential intervention in the treatment of personality disorders and complex character configurations. Young and colleagues (2003) developed specific applications for working with Early Maladaptive Schemas (EMS) and, above all, with modes (distinct emotional and cognitive states representing clusters of schemas, emotions, and behaviors). Chair work in Schema Therapy is distinguished by the frequent use of complex multi-chair configurations, with dialogues that can involve four or more chairs simultaneously (Arntz & Jacob, 2013; Kellogg, 2023). The approach has shown particular effectiveness in the treatment of borderline personality disorder (BPD), characterized by emotional instability, relationship difficulties, and a fragmented sense of self.

Procedural specifics. The procedures include: (1) schema dialogue (or point-counterpoint), a structured dialogue between the "voice" of the maladaptive schema and the patient's healthy adult side, used to weaken the credibility of schemas through disconfirming evidence; (2) mode dialogues, conversations between different modes such as Vulnerable Child, Punitive Parent, Healthy Adult, and dysfunctional coping modes (Detached Protector, Angry Child), with the aim of rebalancing the internal system; (3) historical role-play, re-enactment of traumatic childhood scenes with the integration of corrective adult perspectives and the possibility of "rewriting" the scene; (4) enactive rescripting, imaginative reworking of traumatic events through active role-playing, where the therapist can enter the scene as a protective figure; (5) mode interviews, where the therapist interviews different modes to understand their origin, function, and underlying needs (Pugh & Rae, 2019).

The ST approach is distinguished by greater structuring than the Gestalt tradition. It typically includes a cognitive preparation phase (psychoeducation on modes, identification of target patterns, collection of disconfirming evidence) followed by the actual experiential work. The therapist takes on a more active and guiding role, sometimes entering the scene to offer "limited reparenting" and model healthy responses. Recent literature emphasizes the importance of cognitive post-processing after chairwork, with 62% of patients in a qualitative study identifying this phase as crucial (Schaich et al., 2023).

Clinical goals. The main goals are: (1) weakening EMS through corrective emotional experience rather than cognitive restructuring alone; (2) strengthening the Healthy Adult mode, considered the "true north" of

treatment; (3) integrating split modes and reducing rigidity between modes; (4) developing functional coping strategies to replace dysfunctional patterns; (5) vicarious satisfaction of unmet emotional needs in childhood through limited reparenting.

Empirical evidence. Evidence shows effectiveness in the treatment of borderline personality disorder. A large randomized controlled multicenter study (Arntz et al., 2022) documented that Schema Therapy (both in a predominantly group format and in a combined individual-group format) is superior to standard treatment, with a moderate-high effect size (d = 0.73) maintained over time. The empirical basis of Schema Therapy is among the most robust for Chair Work, with randomized controlled trials supporting its effectiveness. Recent qualitative studies (Schaich et al., 2023) have shown that patients particularly appreciate it when the therapist: (a) provides a sense of security and support during chair work; (b) limits the space given to the Punitive Parent; (c) treats modes seriously; (d) remains physically close while working with the Vulnerable Child. However, it also emerges that some patients experience internal blocks, shame, or difficulty taking the technique seriously, suggesting the importance of addressing avoidant coping modes early on.

Experiential Process Psychotherapy / Emotion-Focused Therapy

Experiential Process Psychotherapy, now known as Emotion Focused Therapy (EFT), developed by Leslie Greenberg and colleagues (Greenberg, Rice, & Elliott, 1993; Elliott, Watson, Goldman, & Greenberg, 2004), has systematized the use of Chair Work for the transformation of emotional experience, configuring these techniques as primary interventions for the resolution of dysfunctional emotional configurations. The EFT approach integrates principles of attachment theory, affective neuroscience, and emotion psychology with a sophisticated theoretical conceptualization that distinguishes between adaptive primary emotions (to be accessed and utilized), maladaptive primary emotions (to be transformed), secondary emotions (to be explored in order to access underlying emotions), and instrumental emotions (to be recognized as a mode of interpersonal control) (Greenberg, 2011).

Procedural specificities. Characteristic procedures include: (1) empty chair for unfinished business, used to resolve unresolved conflicts with significant figures, allowing the expression of blocked primary emotions such as protective assertive anger or grief-related sadness; Paivio and Greenberg (1995) documented the effectiveness of this procedure in a controlled study, showing that experiential therapy with empty chair is significantly superior to group psychoeducation; (2) two-chair for self-critical splits, processing conflicts between the internal critic and the experiential aspect of the self, with the aim of softening self-criticism and developing self-compassion (Shahar et al., 2012; Kroener et al., 2024); (3) two-chair for self-interruptive splits, when one part of the self interrupts or blocks the expression of another part; (4) accessing chair, connection with resources, personal strengths, and adaptive emotions.

EFT follows a well-documented systematic process (Elliott et al., 2004; Watson, 2019): (1) identification of specific emotional markers that indicate when chairwork is appropriate (e.g., criticism of significant figures expressed with resignation for unfinished business; conflicts expressed as "part of me wants... but another part..." for split); (2) collaborative proposal of chairwork with clear rationale; (3) facilitation of emotional activation through expressive techniques, while remaining within the optimal "window of tolerance" (Carryer & Greenberg, 2010); (4) symbolization and differentiation of emotional experience through evocative reflections; (5) facilitation of sequential change in emotional states towards resolution; (6) integration of new emotional experience with the formulation of new meanings.

Research on the micro-processuality of chairwork in EFT has identified specific sequences of emotional states associated with positive outcomes. Pascual-Leone and Greenberg (2007) developed the Classification of Affective Meaning States (CAMS), highlighting how an ordered sequence of emotional states—from global emotions of distress, through reactive emotions such as anger and fear, to reflective emotions such as sadness, and finally to assertiveness and agency—has a synergistic impact in facilitating change.

Clinical objectives. The main objectives concern: (1) the transformation of maladaptive primary emotions (e.g., toxic shame, destructive anger toward oneself) (Capparelli et al., 2022) into adaptive primary emotions (e.g., self-compassion, assertive protective anger); (2) accessing and expressing previously blocked or interrupted

adaptive primary emotions; (3) resolving unfinished business through authentic expression and complete emotional processing; (4) developing self-soothing and adaptive emotional regulation skills; (5) strengthening the sense of agency and narrative coherence of the self.

Empirical evidence. EFT has a particularly robust empirical basis among approaches that use chairwork. Multiple meta-analyses document superior efficacy over waitlist controls and equivalence with cognitive-behavioral approaches for depression, with specific advantages in self-esteem and interpersonal functioning (Elliott et al., 2004, 2021). Comparative studies by Goldman and colleagues (2006) and Greenberg and Watson (1998) have shown that the addition of emotion-focused interventions to client-centered relational conditions produces significant superiority in both the reduction of depressive symptoms and global distress. Watson and colleagues (2003) documented that EFT is as effective as cognitive-behavioral therapy in treating depression, with gains maintained over time.

Recent studies have extended the application of EFT to generalized anxiety disorder (Watson & Greenberg, 2017), childhood abuse trauma (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010), and eating disorders. Kroener and colleagues (2024) conducted a pilot study on a brief (three sessions) emotion-focused chairwork intervention for self-criticism in depressed patients, documenting significant improvements and good acceptability, suggesting that even limited-duration chairwork interventions can produce clinical benefits when well focused.

Transactional Analysis: Redecision Therapy

The integration of Chair Work into Transactional Analysis (TA) through Bob and Mary Goulding's Redecision Therapy (1979) represents one of the most significant historical contributions to the evolution of experiential techniques. This approach combines the theoretical framework of Transactional Analysis (ego states, life scripts, injunctions, and counterinjunctions) with Gestalt Therapy intervention techniques, using chairwork to help clients take ownership of different parts of themselves and resolve old conflicts between ego states.

Procedural specifics. The procedures include: (1) two-chair work for ego states, dialogue between Parent, Adult, and Child for the resolution of intrapsychic conflicts, allowing the exploration of introjected parental messages and their reworking from a contemporary adult perspective; (2) parent interview, chairwork techniques to explore and modify introjected Parent messages, with the client interviewing their “internal Parent” to understand its origins, intentions, and current validity; (3) early scene work, reworking childhood decisions by reliving formative scenes from the past, identifying the decisions made at the time and their current impact; (4) redecision process, facilitating new conscious decisions to replace limiting childhood decisions, with the contemporary Adult “re-deciding” based on current resources and understandings.

The distinctive theoretical framework integrates the concepts of life script, injunctions (verbal and nonverbal messages received in childhood that limit life options), and counterinjunctions (more explicit messages about how one “should” be) with experiential techniques. An original contribution is the focus on Impasse Types—blockages between ego states that require differentiated interventions: Type I Impasse (conflict between Parent and Child from late childhood, typically linked to counter-injunctions such as “Be strong”), Type II (power struggle between Parent and Child from early childhood, linked to injunctions such as “Don't exist”), Type III (primitive intrapsychic conflict in the Child itself, the most difficult to resolve) (Goulding & Goulding, 1979).

Clinical goals. Goals include: (1) identifying and modifying dysfunctional childhood decisions made in response to parental injunctions; (2) resolving impasses between ego states, freeing psychic energy previously bound up in internal conflicts; (3) developing an integrated and functional Adult, capable of mediating between Child needs and Parent messages autonomously; (4) rewriting limiting life scripts, moving from tragic or trivial scripts to constructive and self-determined scripts; (5) taking responsibility for one's choices, recognizing that even childhood decisions were adaptive attempts in the original context.

Empirical evidence. Research shows that Redecision Therapy can effectively treat mental health problems, with participants experiencing positive changes in ego states. Some studies have documented specific applications in contexts of relational crises and issues related to limiting childhood decisions. However, controlled studies

remain limited, with a predominance of case studies and clinical observations derived from intensive practice in residential workshops where this approach has traditionally been developed and taught. The main methodological challenge concerns the difficulty of standardizing an approach that integrates two therapeutic traditions (TA and Gestalt) while maintaining the flexibility necessary to work with the client's emerging material.

Cognitive-behavioral approaches

The integration of Chair Work into cognitive-behavioral approaches (CBT) is a relatively recent development that has benefited greatly from the systematization provided by Matthew Pugh (2017, 2019). Pugh produced the first comprehensive synthesis covering the history, theory, and practice of chairwork in CBT, providing a framework for integrating experiential techniques into structured protocols. The incorporation of chairwork into CBT reflects a progressive openness towards experiential interventions, recognizing that verbal cognitive restructuring alone may be insufficient for some clients and some issues, particularly when dysfunctional beliefs are maintained by automatic emotional systems ("hot cognitions") (Safran & Greenberg, 1982).

Procedural specifics. CBT applications include: (1) cognitive chairwork, dialogue with automatic thoughts and dysfunctional beliefs, where the client moves between a chair that articulates the dysfunctional belief and one that presents alternative evidence; (2) self-criticism chairwork, working with the internal critic through two-chair techniques, allowing the self-critical side to fully express itself before facilitating a compassionate response from the experiential side; (3) behavioral rehearsal, practicing new assertive or coping behaviors through role-playing with chairs, preparing the client for challenging situations; (4) ambivalence resolution, exploration of conflicting motivations for change (e.g., advantages vs. disadvantages of maintaining a problem behavior), using two chairs to represent the conflicting positions; (5) worry chairwork, externalization and management of ruminative processes, where rumination is "put on the chair" and the client learns to relate to it differently (Pugh, 2017, 2019).

CBT chairwork is characterized by a more structured approach: (1) cognitive preparation with identification of specific targets (beliefs to be tested, behaviors to be practiced); (2) use of pre/post intervention rating scales to monitor changes in belief strength or emotional intensity; (3) integration with homework assignments, where the client can continue internal dialogues or practice new responses; (4) focus on measurable and functional behavioral outcomes. Pugh (2018) pointed out that cognitive-behavioral chairwork tends to be more goal-oriented and directive than the Gestalt approach, with the therapist taking a more active role in guiding the content of the dialogues.

A particularly developed CBT application is trial-based cognitive therapy (de Oliveira, 2015), where core beliefs are "tried" as in a court of law, with evidence for and against presented by different chairs, and the client taking on the role of jury to evaluate the verdict. This forensic structure makes the cognitive restructuring process more concrete and engaging for many clients.

Clinical objectives. The objectives include: (1) experiential cognitive restructuring, facilitating change in beliefs not only on an intellectual level but also on an emotional level (felt sense); (2) modification of dysfunctional behavioral patterns through practice and rehearsal in a safe environment; (3) increase in self-efficacy through successful experiences in managing difficult situations during role-plays; (4) developing problem-solving and decision-making skills through externalization of different options; (5) reducing dysfunctional cognitive processes such as rumination and brooding through defusion and distancing.

Empirical evidence. Results show promising outcomes for anxiety disorders and depression. De Oliveira and colleagues (2012) documented that trial-based cognitive therapy with chairwork is effective for social phobia. However, specific controlled research on chairwork in CBT remains limited. Pugh (2017) identified only a small number of controlled studies that isolate the specific contribution of chairwork compared to other CBT components in his narrative review. The meta-analysis by Pascual-Leone and Baher (2023) highlighted that therapeutic orientation emerges as a potential moderator of effects, suggesting that different approaches may optimize different aspects of the change process. Future studies should use dismantling designs to identify the active components of chairwork in CBT contexts and determine for which clients and issues this technique adds

value beyond standard CBT interventions.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) has developed innovative applications of chairwork in the context of psychological flexibility and cognitive defusion processes. The ACT approach, based on Relational Frame Theory and the psychological flexibility model (Hayes et al., 2012), uses chairwork to facilitate distancing from problematic mental content and identification with the "observing self" rather than with the contents of the mind.

Procedural specifics. ACT-specific procedures include: (1) observer self chairwork, dialogue between the observing self (the conscious context that remains constant) and the conceptual self (the set of beliefs about "who I am"), facilitating perspective taking and the recognition that "I am not my thoughts"; (2) values clarification chair, exploration of values through dialogue with the "future self" who has lived according to their values, helping the client to connect emotionally with what really matters; (3) defusion chairwork, externalization of difficult thoughts and beliefs by "putting them on the chair" to observe them with detachment rather than being dominated by them; (4) acceptance process chair, facilitation of acceptance of difficult internal experiences (emotions, sensations, memories) through dialogues that explore the costs of avoidance and the benefits of openness.

Clinical objectives. Objectives include: (1) developing perspective-taking and the ability to observe one's own mental processes from a decentralized position; (2) increasing psychological flexibility, understood as the ability to be fully present and to act in accordance with one's values even in the presence of difficult internal experiences; (3) clarification and value commitment, moving from fusion with extrinsic goals to connection with meaningful intrinsic values; (4) reducing experiential avoidance, recognizing that attempts to control or eliminate painful internal experiences paradoxically amplify suffering.

Empirical evidence. Evidence is emerging but promising, particularly for conditions characterized by high psychological rigidity and pervasive patterns of experiential avoidance. Specific controlled research on chairwork in ACT is still in its early stages. However, studies on broader ACT interventions incorporating elements of chairwork show effectiveness for conditions such as chronic pain, anxiety, depression, and eating disorders. The methodological challenge concerns isolating the specific contribution of chairwork from other ACT techniques such as metaphors, experiential exercises, and mindfulness practice.

Compassion Focused Therapy

Compassion Focused Therapy (CFT), developed by Paul Gilbert (2010), has recently integrated chairwork as a central technique for developing self-compassion skills in clients with high levels of self-criticism and shame. Bell and colleagues (2021, 2023) have conducted in-depth qualitative research on the subjective experience of compassion-focused chairwork, highlighting its transformative mechanisms.

Procedural specifics. Compassion-focused chairwork typically involves: (1) dialogues between the "compassionate self" (an ideal, wise, and loving version of the self) and vulnerable or critical parts; (2) embodiment of the "ideal compassionate figure" through guided imagery followed by chairwork where the client physically experiences what it means to "be" this figure; (3) work with voice-hearing in psychosis, where voices are externalized onto chairs and the client develops compassionate responses to them (Heriot-Maitland, 2025).

Empirical evidence. Recent studies (Bell et al., 2021) have documented that participants experience compassion-focused chairwork as deeply transformative, with changes described in terms of "multiplicity, transformation, and integration." Bell and colleagues (2023) have highlighted how this technique modifies the quality of the therapeutic relationship, with a particular impact on the perception of safety and the possibility of authentic expression.

Contemporary developments: theoretical and methodological systematizations

Contemporary methodological developments have benefited from various systematizations that transcend theoretical boundaries. Matthew Pugh has developed sophisticated operational frameworks for evidence-based

implementation through the Chairwork.co.uk research center, proposing a model based on four fundamental dimensions: principles (presence, embodiment, multiplicity, dialogue), processes (separation, animation, integration), procedures (empty chair, two-chair, multi-chair, role-play) and process skills (facilitation of dialogue, management of resistance, timing of interventions) (Pugh & Bell, 2020).

Scott Kellogg (2004, 2015, 2023; Kellogg & Garcia Torres, 2021) proposed the "Four Dialogues" model as a unifying framework that organizes all applications of chairwork: (1) Giving Voice, giving voice to parts of the self that have never been able to express themselves; (2) Internal Dialogues, facilitating dialogues between conflicting aspects of the self; (3) Telling the Story, narrating traumatic experiences from different temporal perspectives and subjective positions; (4) Relationships and Encounters, working with interpersonal relationships through dialogues with significant figures. This model, originally developed for Schema Therapy, has shown cross-applicability to multiple approaches.

Recent procedural innovations include: (1) process-based chairwork, prioritizing therapeutic mechanisms (e.g., emotional activation, perspective-taking, experiential integration) over specific content; (2) single-session protocols for intensive interventions, with evidence that even a single well-conducted session can produce significant change (Pascual-Leone & Baher, 2023); (3) adaptations for telematic settings, with specific guidelines to facilitate effective chairwork in videoconferencing despite the limitations of reduced spatial dimensions (Pugh et al., 2021); (4) supervisory applications, using chairwork in clinical training to work on countertransference dynamics and develop therapists' reflective skills.

Emerging integrative models combine elements from heterogeneous traditions, characterized by: case-sensitive procedural flexibility, with the choice of techniques based on case formulation rather than rigid adherence to protocols; integration of somatic and mindfulness-based approaches, incorporating body awareness and mindful presence during chairwork; implementation of innovative digital technologies, such as video feedback for post-session review of chairwork and experimentation with virtual reality environments to create immersive contexts for experiential work.

Comparative analysis: common mechanisms and distinctive specificities

Systematic analysis reveals core mechanisms that unify the different applications of Chair Work across heterogeneous theoretical models. The fundamental mechanisms identified include:

Spatial concretization. Chairwork transforms abstract intrapsychic processes into concrete and tangible spatial configurations. This process of externalization facilitates the observation and manipulation of psychological dynamics that would otherwise remain implicit and difficult to access. Research on enactment and memory for actions (Engelkamp, 1998) suggests that the motor experience of physically moving between chairs and embodying different positions amplifies the cognitive and emotional impact of the intervention compared to verbal dialogue alone.

Modulation of emotional arousal. Chairwork allows for flexible regulation of emotional intensity, facilitating access to optimal emotional states for processing. Carryer and Greenberg (2010) documented that moderate levels of emotional arousal (neither too low nor overwhelming) during chairwork predict better therapeutic outcomes. The therapist can intensify the emotional experience through evocative techniques or, conversely, modulate it downward when the client approaches the limits of their window of tolerance.

Perspective-taking and decentering. The physical change of chair facilitates the adoption of multiple perspectives on the same situation, promoting cognitive flexibility and the ability to decentrate. This ability to "see through the eyes of another" – whether it be an aspect of the self, a significant figure, or the ideal future self – corresponds to mentalization and theory of mind processes that are often deficient in clinical populations (Rainauli, 2025).

Experiential integration. Chairwork facilitates the integration of dissociated or fragmented aspects of experience through dialogue and the exchange of emotionally salient information between "parts." This integration is not merely cognitive but involves multiple levels of processing (sensory, emotional, narrative, relational), producing identity coherence and a sense of wholeness.

Creation of self-complexity. As argued by Pugh (2017), chairwork naturally generates a multifaceted representation of the self, challenging the monological qualities of pathological cognition. As different "voices" exchange information during dialogues, a richer and more nuanced understanding of subjective experience emerges (Hermans et al., 1992). The phenomenal field, understood as the horizon of probability of emergence of phenomena in the current situation (Francesetti, 2024), constitutes the matrix from which these dialogical experiences emerge.

Specific differentiations emerge in clinical finalizations and modes of conduct. Gestalt privileges phenomenological awareness and existential empowerment, with an emphasis on the "here and now" of experience. EFT pursues transformations in the affective economy, specifically targeting the transformation of maladaptive emotions through access to adaptive emotions. Schema Therapy aims at restructuring established character configurations (schemas and modes), with a strong emphasis on reworking traumatic childhood experiences. CBT approaches optimize cognitive-behavioral outcomes, using chairwork as a "laboratory" to test and modify beliefs. ACT facilitates defusion and psychological flexibility, with a focus on the relationship with mental content rather than on modifying the content itself. CFT specifically develops self-compassion skills to counteract pervasive self-criticism and shame.

From a procedural point of view, there is a continuum of structuring that ranges from Gestalt phenomenological spontaneity (where the therapist follows the emergence of the process moment by moment) to the protocol standardization of cognitive-behavioral approaches (with predefined phases, a priori identified targets, and pre-post measures). Similarly, therapeutic directivity highlights polarizations between non-directive approaches (Gestalt, humanistic orientations, where the therapist facilitates rather than guides) and more structured modalities (CBT, Schema Therapy, where the therapist takes a more active role in orchestrating dialogues).

Analysis of target populations reveals partial specializations but with significant overlap: ST is particularly effective with personality disorders and complex character configurations; EFT optimizes results in relational, post-traumatic, and depressive settings; CBT approaches excel with anxiety and mood disorders; GT maintains cross-cutting versatility. This overlap suggests the inherently transdiagnostic nature of Chair Work, with common mechanisms operating across different clinical presentations, while procedural specificities allow for optimization for particular issues.

DISCUSSION

Strengths of the different approaches

Each therapeutic model has distinctive advantages in the use of Chair Work.

Gestalt Therapy maintains procedural flexibility that allows real-time adaptations to emergencies in the therapeutic process, encouraging authentic exploration of experience without imposing predefined structures. This feature is beneficial with clients who have difficulty accessing their emotions or patterns of excessive control, allowing meaningful material to emerge organically. Furthermore, the Gestalt emphasis on existential responsibility and phenomenological awareness facilitates the development of metacognitive skills that extend beyond the therapeutic context.

Schema Therapy excels in the theoretical systematization and specificity of interventions, offering a clear conceptual framework (schemas, modes, emotional needs) that facilitates understanding of the mechanisms of change. The cognitive preparation that precedes experiential work promotes the engagement of clients who are initially reluctant to experiential techniques, while the conceptualization of modes provides a shared language that optimizes therapeutic collaboration. The limited reparenting model, where the therapist actively enters scenes to offer corrective experiences, is particularly powerful for clients with histories of severe emotional deprivation.

Emotion-Focused Therapy has a robust empirical base and a sophisticated theory of emotional change that guides the selection and timing of interventions. The systematization of emotional markers (procedural indicators of when specific tasks are appropriate) and resolution procedures provides valuable clinical guidance, reducing

arbitrariness in the choice of techniques. Integration with attachment principles amplifies effectiveness with clients who have primary relational difficulties, while micro-process research on optimal emotional sequencing informs moment-by-moment facilitation.

Redecision Therapy provides a theoretical bridge between humanistic approaches and structured intrapsychic dynamics, with clear conceptualizations of change processes at the ego state level that many clients find accessible and immediately understandable. The emphasis on conscious decisions and personal responsibility facilitates client empowerment and generalization of change, with the shift from "victim of circumstances" to "agent of one's own choices" having a transformative impact on identity narrative.

CBT approaches offer the advantage of systematic integration with evidence-based protocols, facilitating the incorporation of chairwork into manualized treatments and its acceptance in institutional contexts that favor empirically supported interventions. The ability to combine experiential processing with cognitive and behavioral homework amplifies the impact through multiple modes of intervention, while the structuring and goal orientation are consistent with the expectations of many clients and contemporary healthcare systems.

Specific limitations and challenges

Each approach has limitations that restrict its applicability.

Gestalt Therapy may be overly non-directive for clients who need more structure, particularly those with deficits in mentalization abilities or borderline personality organizations that require active containment. The lack of standardized protocols complicates replicability and empirical evaluation, contributing to the scarcity of controlled studies and limiting the spread of the approach in contexts that favor manualized interventions.

Schema Therapy may be overly complex for clinicians without specific intensive training, with the conceptualization of schemas and modes requiring theoretical sophistication and considerable time to master. Extensive cognitive preparation, while useful for engagement, can reduce the spontaneity of emotional experience and promote intellectualization, particularly in clients with hypercontrolling coping styles. Furthermore, working with complex trauma requires specialized skills in managing dissociative states and modulating arousal.

EFT shows limitations with clients who have severe emotional regulation difficulties or fragile personality structures, where the emotional intensification characteristic of the approach can be destabilizing rather than therapeutic. The specificity of the training required (typically intensive 1-2 year certification programs) is a barrier to widespread implementation. Furthermore, the emphasis on emotional activation may be incongruent with cultural preferences in contexts that value emotional control and interpersonal harmony.

CBT approaches may encounter difficulties with clients who favor experiential and emotional modes over cognitive and rational ones, with the risk that chairwork may be experienced as artificial or overly technical. The emphasis on structuring may limit the exploration of unexpected emerging material, while the tendency to "correct" rather than "explore" may conflict with some clients' needs to simply be listened to and validated. The tension between standardization (required for research and dissemination) and flexibility (necessary for clinical responsiveness) remains a significant challenge.

Cross-cutting limitations include: (1) lack of clear guidelines on when not to use chairwork, with the risk of inappropriate application in situations of high dysregulation or with clients who are not sufficiently stabilized; (2) insufficient attention to cultural differences in emotional expression and self-concept, with techniques developed primarily in individualistic Western contexts that may be less appropriate in collectivist cultures or cultures with different norms of emotional expressivity; (3) the need for sophisticated therapeutic skills to manage intense activations and resistance, with the risk that less experienced clinicians may overestimate their own skills.

Common mechanisms and procedural differences

The comparative analysis highlights cross-cutting mechanisms of action alongside distinctive procedural

specificities. The common mechanisms operate at multiple levels: neurobiological (activation of autobiographical memory systems and default mode networks during immersion in dialogue), cognitive (restructuring through perspective-taking and integration of discrepant information), emotional (processing through full experience rather than avoidance), relational (correction of internal operating models through new interpersonal experiences, including the therapeutic relationship), narrative (construction of more coherent and complex self-stories).

However, procedural differences reflect divergent underlying epistemologies and theoretical assumptions. Gestalt emphasizes phenomenological awareness of "how it is" in the present moment, with less interest in causal understanding of "why"; the therapist facilitates rather than interprets, following the client's genuine interest. EFT focuses on the sequential transformation of emotional states, actively guiding toward adaptive primary emotions through identifiable procedural markers; the therapist is both an empathetic facilitator and an expert guide of the emotional process. Schema Therapy aims at characterological restructuring through the reworking of formative experiences and vicarious satisfaction of unmet needs; the therapist assumes a "corrective" parental role through limited reparenting. CBT optimizes cognitive-behavioral outcomes through experiential testing of beliefs and the practice of new behavioral repertoires; the therapist is a scientific collaborator who helps the client conduct "experiments."

These differences manifest themselves concretely in the degree of structuring. On the structuring continuum, Gestalt is positioned toward maximum spontaneity (following moment-by-moment emergencies without a predefined agenda), EFT occupies an intermediate position (with specific markers and tasks but flexible implementation), while Schema Therapy and CBT tend toward greater structuring (with predefined phases and targets identified a priori). Preliminary preparation varies similarly: from minimal Gestalt psychoeducation to the extensive phase of schema-therapeutic conceptualization.

Therapeutic directiveness highlights related polarizations: non-directive approaches (Gestalt, humanistic orientations) favor following the client's process, while directive modalities (CBT, Schema Therapy) involve active guidance of the content and process of dialogues. However, this distinction is more nuanced than it seems: even Gestalt therapists actively intervene to facilitate awareness and contact, while schema-focused therapists respect the client's timing and pace. The difference perhaps lies more in the explicitness of the structuring than in the actual degree of therapeutic influence.

The preferred outcomes differ: Gestalt values awareness and existential empowerment as ends in themselves; EFT pursues specific emotional transformation (from maladaptive to adaptive); Schema Therapy aims at lasting character changes and mode integration; CBT favors measurable symptomatic modification. However, in clinical practice, these distinctions become blurred: Gestalt awareness often produces symptomatic reduction; CBT symptomatic modification often accompanies changes in self-structure; EFT emotional transformation involves observable behavioral changes.

Implications for clinical practice

For clinicians, the findings suggest the importance of acquiring cross-cutting skills that allow for flexible adaptation of Chair Work to different needs. Rather than rigid adherence to specific protocols of individual approaches, mastery of fundamental principles (presence, embodiment, multiplicity, dialogue) allows for contextualized and responsive application (Pugh & Bell, 2020) . Understanding common mechanisms (spatial concretization, emotional modulation, perspective-taking, integration) facilitates the creative integration of elements from different approaches, while awareness of distinctive specificities helps in selecting the model most congruent with clinical presentation, client preferences, and therapeutic context.

Training should emphasize fundamental procedural skills: (1) skill in controlled emotional activation, knowing when to intensify and when to modulate downward according to the client's window of tolerance; (2) facilitation of internal dialogue, using evocative questions, reflections, and interpretations that amplify rather than direct; (3) resistance management, recognizing that reluctance to chairwork may stem from shame, fear of losing control, or cultural incongruity rather than characterological "resistance"; (4) integration of experience, helping the client consolidate insights and transform them into meanings that can be used outside the session.

The ability to adapt the conduct of the session to the client's level of development and specific needs emerges as a critical skill. With clients with mentalization deficits, greater structuring and preliminary psychoeducation are necessary. With hyper-controlling clients, an emphasis on experimentation and curiosity rather than predefined outcomes reduces performance anxiety. With dissociative clients, attention to grounding and co-regulation become priorities over emotional intensification. With clients from collectivist cultures, framing chairwork as an exploration of "internalized family voices" rather than "parts of the self" may be more culturally congruent.

Implementation in practice requires attention to practical barriers: (1) time constraints, with the development of single-session protocols that allow for effective use even in short contexts; (2) client resistance, which can be addressed through normalization ("many people find this technique strange at first"), clear rationalization, and gradual introduction; (3) therapist comfort levels, with supervision and personal practice of chairwork (experiencing from within) facilitating mastery; (4) inadequate physical settings, with the need for sufficiently large and private spaces.

Adaptation for tele-therapy (Pugh et al., 2021) requires specific measures: use of household objects as spatial markers to replace chairs; greater verbal structuring of the spatial dimension ("when you are in this position..."); increased attention to technical disconnections that can interrupt the experiential flow. However, research indicates that chairwork remains effective even in an online format when appropriately adapted.

Supervision practices can benefit from incorporating chairwork both for training purposes (e.g., the supervisee "becomes" their own patient to develop empathy and understanding) and to address the supervisee's personal growth needs (e.g., working on problematic countertransference or blockages through dialogues between "me-therapist" and "me-person"). Pugh and colleagues have demonstrated the usefulness of these supervisory approaches.

Implications for future research

Priority areas for research include methodological development, investigation of mechanisms, effectiveness studies, and personalized approaches.

Methodological development. There is a need to develop manualized protocols that maintain essential clinical flexibility while providing sufficient standardization for rigorous empirical evaluation. Balancing structure and spontaneity requires sophisticated approaches: manualization of principles and processes rather than specific procedures, allowing variability in implementation while maintaining fidelity to active mechanisms. Fidelity research should assess adherence to core principles rather than compliance with rigid scripts.

Future studies should use multiple methodological designs: randomized controlled trials for efficacy, with active controls in addition to waitlists to estimate specific effects; naturalistic and effectiveness studies to evaluate implementation in real-world settings; single-case designs with repeated measurements to capture individual variability and identify idiographic predictors of response; qualitative studies to deepen understanding of subjective processes of change.

Research on mechanisms. A detailed understanding of the psychological processes underlying the effectiveness of chairwork requires investigation using advanced methodologies. Functional neuroimaging could identify patterns of brain activation during different types of chairwork, testing hypotheses about the neural networks involved (e.g., default mode network for internal perspectives, theory of mind network for perspective-taking). Psychophysiological monitoring (heart rate variability, skin conductance, facial electromyography) could track moment-by-moment emotional arousal, informing the optimal timing of modulatory interventions. Micro-processual analysis of video-recorded sessions using validated coding systems (CAMS for emotional states, Experiencing Scale for experiential depth) could identify processual sequences associated with positive outcomes.

Research should test competing theoretical models of mechanisms: does chairwork operate primarily through cognitive restructuring (as suggested by CBT theorists), emotional transformation (EFT position), modification of characterological patterns (Schema Therapy), or a synergistic combination of multiple processes? Mediation

designs could test which process (change in beliefs, emotional states, mode configuration) temporally precedes and predicts symptomatic change.

Effectiveness and implementation studies. Real-world evaluation of the implementation of chairwork in routine clinical practice requires effectiveness studies that assess clinical outcomes, practical factors (feasibility, acceptability, cost-effectiveness), and implementation processes. Particular attention should be paid to: (1) barriers to adoption identified by clinicians (lack of training, time constraints, doubts about effectiveness); (2) facilitating strategies (focused brief training, supportive supervision, communities of practice); (3) sustainability of implementation over time; (4) equity of access, ensuring that disadvantaged populations are not excluded from effective interventions.

Implementation science studies should use established frameworks (e.g., Consolidated Framework for Implementation Research) to systematically identify facilitators and barriers at multiple levels: individual (clinicians' attitudes and skills), organizational (institutional culture and resources), and systemic (health policies and reimbursement models).

Personalized approaches. The development of predictive models to identify clients most likely to benefit from different chairwork modalities is a critical frontier. Research should explore moderators of effectiveness: demographic characteristics, diagnostic patterns, levels of mentalization, preferences for experiential vs. cognitive modalities, cultural variables, and quality of the therapeutic alliance. Machine learning approaches could analyze large datasets to identify subtle patterns of interaction between client characteristics, specific procedures, and outcomes.

Future research should also investigate: (1) optimal dosage (frequency and intensity of chairwork during treatment); (2) timing in the therapeutic process (when to introduce chairwork to maximize effectiveness); (3) synergistic combinations with other techniques (e.g., chairwork followed by experiential homework); (4) innovative formats (e.g., virtual reality chairwork, mobile applications for practice between sessions).

Finally, crucial attention should be paid to cultural adaptations and verification of cross-cultural effectiveness.The majority of research comes from individualistic Western contexts; studies in collectivist cultures, with different conceptions of the self and emotional expression, are necessary to understand generalizability and identify necessary changes.

CONCLUSION

This narrative review has provided an overview of Chair Work applications across heterogeneous theoretical frameworks, highlighting the universality of the underlying mechanisms and the diversity of its application specifications. The emergence of Chair Work as a trans-theoretical methodology is the most significant result, indicating the existence of therapeutic invariants that transcend conventional disciplinary boundaries.

Chair Work maintains coherence in its core operational substrates—spatial concretization of intrapsychic dynamics, modulation of affective arousal to facilitate integrative processing, implementation of perspective-taking to increase cognitive flexibility, orchestration of synthetic processes for dissociated aspects of experience—while significantly diversifying in its clinical goals and procedural orchestrations. This configuration suggests the potential for integrative frameworks that preserve theoretical richness while maximizing implementation effectiveness.

Empirical assessment demonstrates both promise and shortcomings. A recent meta-analysis by Pascual-Leone and Baher (2023) found that a single chairwork session was more effective than empathic listening in facilitating experiential deepening (d = .90), while for symptom reduction it produced substantial pre-post changes (d = 1.73) but with equivalent efficacy to other active interventions (d = .02). The most robust effect emerged when chairwork was used repeatedly throughout treatment, accumulating a significant effect (d = .40) compared to treatments that did not use it. These findings provide empirical support for the clinical utility of chairwork, particularly as a recurrent process intervention. However, the predominance of qualitative paradigms and case studies in some approaches (particularly Gestalt and TA), although valuable for phenomenological process

understanding, limits the generalizability and consolidation of evidence-based protocols. Paradoxically, approaches with more consolidated empirical traditions (EFT, Schema Therapy for personality disorders) demonstrate superior methodological sophistication with multiple controlled trials, while approaches with more extensive clinical legacies (Gestalt) maintain practical robustness but inferior investigative systematization. This asymmetry reflects both epistemological differences (with Gestalt phenomenology historically skeptical of quantification and standardization) and pragmatic factors (research funding, the prevailing academic culture in the centers where the different approaches are developed).

The transdiagnostic applicability of chairwork suggests particular value in the era of process-based approaches, where interventions that target common underlying mechanisms (emotional dysregulation, self-criticism, interpersonal difficulties, cognitive rigidity) provide greater efficiency and flexibility than syndrome-specific protocols. Chairwork's ability to simultaneously address multiple domains—cognitive (restructuring beliefs), emotional (transformation of affective states), relational (modifying internal working models), behavioral (practicing new repertoires), and narrative (constructing more coherent self-stories)—aligns with contemporary understandings of the interconnectedness of psychological processes and the need for multilevel interventions for lasting change.

Clinical training needs to evolve toward competency-based approaches that emphasize transferable skills (principles, processes, process skills) rather than adherence to rigid models. Experiential learning should allow students to experience chairwork from multiple perspectives—as clients (inside experiencing), as observers (vicarious learning), and as supervised therapists—facilitating an embodied understanding of the psychological processes involved that goes beyond merely intellectual knowledge (Geniola et al., 2025).

Evolutionary perspectives could include: integration with neurofeedback technologies to optimize real-time emotional arousal; development of immersive virtual reality environments that amplify the impact of spatial concretization; machine learning-based therapeutic personalization algorithms that identify the "optimal chairwork" for each client; and mobile applications that support practice between sessions (Di Sarno et al., 2025). However, the core value will remain anchored in the fundamental human capacity for transformation through authentic experiential engagement in a safe therapeutic relationship—a capacity that Chair Work appears particularly suited to facilitating in contemporary clinical contexts.

In summary, Chair Work emerges as a family of interventions characterized by applicative versatility and transversal therapeutic potential. Mapping its applications across different therapeutic models highlights both the richness of its theoretical specifications and the common underlying mechanisms. Strengthening the empirical base through methodologically rigorous research—with controlled trials, dismantling studies to identify active components, mechanism research using multi-method methodologies, effectiveness studies in naturalistic settings, and investigation of response predictors for optimal matching—remains a fundamental priority for the full scientific recognition and optimal implementation of these promising interventions. The convergence of independent theoretical developments across multiple therapeutic traditions indicates that chairwork touches something fundamental in human processes of change and growth, deserving of the substantial attention it is receiving from the contemporary clinical and research community.

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