The Transdiagnostic Phenomenon of Self-Criticism

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Three interventions used to assist highly self-critical patients develop self-compassion are described and illustrated with case material. Theoretical background, assumed mechanism of change, and research evidence for each intervention is presented.

Keywords: self-criticism, self-compassion, Cluster C personality disorder, affect phobia

In the past 20 years, research has established excessive self-criticism as a transdiagnostic phenomenon that plays a role in the development and maintenance of a range of psychological disorders (Gilbert & Irons, 2005). Several therapeutic approaches have consequently developed interventions targeted at helping patients cultivate a more compassionate and caretaking stance toward themselves (Gilbert & Irons, 2005; McCullough Vaillant, 1997). Various definitions of compassion all involve the qualities of kindness, gentleness, and warmth (Gilbert, McEwan, Matos, & Rivas, 2011). A more compassionate orientation toward oneself is believed to regulate difficult emotions and reduce negative rumination and such contribute to a lessening of symptoms, interpersonal problems, and social isolation (see Gilbert et al., 2011). Empirical findings indicate that individuals who are more self-compassionate tend to have more social connectedness and less anxiety, depression, shame, fear of failure, and burnout (Barnard & Curry, 2011).

One category of individuals with particular proneness to shame and excessive self-criticism are those with a Cluster C personality disorder (Benjamin, 2003; Schoenleber & Berenbaum, 2010). Increased self-compassion is demonstrated to be associated with improvements in psychiatric symptoms, interpersonal problems, and personality pathology within this diagnostic group (Schanche, Stiles, McCullough, Svarberg, & Nielsen, 2011).

This article aims to specify and illustrate three main interventions that can be used when working with highly self-critical patients. The interventions will be illustrated with a case of a female patient diagnosed with avoidant personality disorder. This patient had a pervasive tendency to treat herself in a critical and self-defeating manner. The main goal of the interventions was to promote her ability to relate to herself with more self-compassion, that is, to treat herself more kindly and with more acceptance and less criticism. The interventions were mainly drawn from two different therapeutic approaches, a short-term psychodynamic model developed by Leigh McCullough (McCullough Vaillant, 1997) and social mentality theory developed by Paul Gilbert (Gilbert & Irons, 2005). In addition, specific techniques were integrated from the sensory motor approach of Pat Ogden (Ogden, Milton, & Pain, 2006). The theoretical basis for each intervention, proposed mechanisms of change, and existing research supporting each intervention will be presented.

A Short Case Description

Anna (not her real name), a 32-year-old Caucasian woman, reported long-standing pervasive worry over potential rejection. Fear of being humiliated and ridiculed had made her avoid close friendships since early childhood. After living alone for years, she did nevertheless establish a relationship with a man when she was 30 years old. She experienced being in a close relationship as demanding. She lived with the expectation that if she made a mistake, others, including her partner, would change their whole view of her. Before social encounters, she experienced a stream of negative predictions, such as “They will think I am boring,” or “They will probably not like me.” After the event, she frequently engaged in anxious rumination over themes of personal inadequacy and failure. She avoided new social encounters whenever possible. In addition to her characteristical self-critical and avoidant traits, Anna had developed symptoms of depression. When entering therapy, she expressed a lack of hope that she would ever feel at ease with herself and others.

Anna met for a total of 30 weekly psychotherapy sessions. Her self-critical habit was chosen as the central therapeutic focus, as negative self-evaluation seemed to be a driving force in her interpersonal problems, personality pathology, and her recurring depressive episodes. The main goal of treatment was to help Anna develop a heightened tolerance for own negative affects and an ability to treat herself with more kindness and gentleness in difficult situations. It was assumed that if Anna could let herself be informed by her affects and treat herself in a more compassionate manner, she would be better able to regulate difficult emotions and inhibit self-critical and catastrophic rumination, which contributed to maintenance of her avoidant traits and recurring depressions.

In the following, an attempt will be made to explicate three main objectives that we tried to accomplish to help Anna develop a more self-compassionate stance: (1) affect experience through gradual

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1 Patient-related material has been camouflaged and may not cause personal identification. The patient represented in the case has also provided written consent for the use of the material after reviewing it.
Self-criticism will no longer automatically block information inherent in affects important for navigating in various interpersonal situations with consideration for one’s own needs (McCullough et al., 2003).

The process of treating affect phobias is similar to treating phobias for external objects, that is, desensitization, where extinction of a conditioned response (defensive behavior) takes place by the presentation of conditioned stimulus (an adaptive affect) without the presence of the unconditioned aversive of fear- or shame-eliciting stimulus (social punishment, rejection, or abuse) (McCullough Vaillant, 1997). Patients are guided to experience their previously avoided affects through exploring mental images of affect-laden situations. During the exposure, the therapist assists the patient in shifting his or her focus of attention between the image itself and the experienced physical sensations the image arouses. Through repeatedly experiencing the physical activation associated with a specific affect, the patient is expected to develop a higher tolerance for this affect.

Based on this theory of change, it was hypothesized that gradual and repeated exposure to anger and sadness would both reduce the eliciting of self-criticism as a defensive strategy and allow Anna to access information inherent in anger and sadness, strengthening her ability to navigate in interpersonal relationships with less negative rumination.

**Verbatim Clinical Exchange**

*T: Can you bring up the image of your mother, as you described her, with her shoulders bent, complaining about her life and how you don’t support her enough? Do you notice how your body reacts when you stay with this image? What physical sensations do you recognize?*

*P: I can feel something here (points to her mid belly)*

*T: Good, anything else?*

*P: My arms feel strong.*

*T: Just stay a little with your arms and belly. What physical sensations do you notice?*

*P: It feels warm, like energy moving.*

*T: When you focus on that energy, can you return to the image and imagine how you would let your mother know how much she hurts you by being so self-centered?*

Anna imagined telling her mother that she had enough of her complaining. She was also able to allow herself to imagine holding on to her mother’s shoulders firmly to prevent her from looking away or leaving the situation. She was repeatedly asked to shift the focus to her body to notice the physical sensations of self-assertion and anger, describe these sensations, and allow them to be there. We repeated several similar and relatively mild exposures both for anger and for sadness during the treatment.

**Proposed Mechanisms of Change**

Self-critical attitudes are understood as an individual’s effort to defend against adaptive affects that have become associated with anxiety, shame, guilt, and pain (inhibitory affects) as a result of early learning experiences. The self-critical patient, according to APT, needs to develop a less phobic relationship to own affects. The need to defend against affects will then be reduced, and self-criticism will no longer automatically block information inherent in affects important for navigating in various interpersonal situations with consideration for one’s own needs (McCullough et al., 2003).

**Empirical Evidence**

Findings from the previously published randomized clinical trial comparing the effectiveness of cognitive therapy and McCullough’s Short-Term Dynamic Psychotherapy for Cluster C personality disorders (Svarberg, Stiles, & Seltzer, 2004) showed that an increase in the experience of affects such as anger and sadness (activating affects) were significantly associated with higher self-compassion toward the end of treatment (Schanche et al., 2011). Shahar et al. (2012) demonstrated that...
an emotion-focused intervention was associated with significant increases in self-compassion and significant reductions in self-criticism, depressive symptoms, and anxiety symptoms. Level of cognitive-affective processing has also been found to be related to other changes in self-relating, such as increase in patients’ self-esteem (Adams & Greenberg, 1996) and positive changes in patients’ self-concept (Day, 1994). An experiential treatment approach including the use of specific process-directive gestalt and experiential interventions also proved to have superior effects on self-esteem and interpersonal problems compared with the same approach not including these specific interventions (Greenberg & Watson, 1998).

Interventions that facilitate patients’ affective experience are further reported to be associated with display of other positive changes in psychotherapeutic outcome both in psychodynamic and cognitive therapy (McCullough & Gill, 2009). A thorough review of details of this research is provided by Diener and Hilsenroth (2009). Findings from McCullough et al. (1991) and Porter as sited in McCullough (2000) show that patients’ outcomes were better when therapist interventions led them to experience their affects compared with when they responded with further avoidance. In a sample where several of the patients had a personality disorder diagnosis, Hilsenroth and colleagues found that therapists’ in-session encouragement of patients to experience and express their feelings was associated with reduction in depressive symptoms (Diener, Hilsenroth, & Weinberger, 2007).

Second Intervention: Establishing and Rehearsing an Inner Compassionate Image and Dialogue

Anna felt she continually had to try to please others, including her partner. Whenever her partner showed signs of being discontent, she easily interpreted his discontent as a direct criticism of her as a person, which triggered an overwhelming sense of inadequacy and worthlessness. When feeling criticized, she would typically retreat into her bedroom. When alone, she felt emotionally detached and cried in desperation. She would then ruminate about how others were not trustworthy and that her partner probably was planning to leave her. Such imagined scenes would leave her with a high level of stress and hopelessness and with a strengthened sense of detachment.

Theory

According to Paul Gilbert’s social mentality theory, an internal and critical self-evaluative relationship can be understood as a form of automatic submissive behavior as a result of an overstimulated and poorly regulated threat system (Gilbert & Procter, 2006). Based on negative experience with subordinate relationships to caregivers, the individual learns to relate to himself in controlling and coercive ways, often in the form of self-talk and inner hostile voices (Gilbert & Irons, 2005). An internal self-evaluative dialogue that is overly critical and shame prone is associated with perceptions of low social rank in relation to others (Gilbert, 2010). Phenomenologically, this submissive position is experienced as inferiority, inability, powerlessness, and personal failure. Self-critical individuals are thought to have underelaborated and underdeveloped capacities for compassionate self-soothing thoughts and images (Gilbert & Irons, 2005). In affect phobia treatment (McCullough et al., 2003), it is a specific goal to change an individuals’ negative sense of self through establishing inner images of supportive compassionate others (McCullough et al., 2003). Paul Gilbert’s (2010) model for self-compassionate mind training can be said to concur with, and also extend, this aspect of McCullough’s theory.

Proposed Mechanism of Change

Mobilizing mental images of compassionate others is believed to help the individual recover from a submissive position through activating processing systems for attachment and security (Gilbert & Irons, 2005). The activation of safe attachment is assumed to have a soothing effect and to contribute to a lessening of the habitual tendency to self-criticize. Focusing on images of caring others is thought to stimulate and elaborate specific neural pathways and thus to strengthen the feeling of safety, love, and being lovable (Gilbert & Irons, 2005, p. 290). Internal signals, like images, can produce bodily responses and have a soothing effect on emotional activation. As in object relations theory (Fairbairn, 1952; Greenberg & Mitchell, 1983), relationships between internalized experiences of self with others are believed to pattern the sense of self and to regulate emotion (Gilbert & Irons, 2005).

In line with Gilbert & Irons (2005) and McCullough et al. (2003), it was hypothesized that gradual and repeated exposure to mental imagery of a supportive other could function as a possible antidote to emotional detachment for Anna. In addition, compassionate imagery was supplemented with a sensory motor action, in which she used her own hand to stroke her head. As tactile and kinesthetic sensations guide early attachment behavior and help regulate the infant’s physiology (Shore, 2003), stimulating soothing sensations through gentle stroking movements can be understood as stimulating attachment and regulating emotions. Using supportive movements is thus thought to further activate the attachment system and help the individual retrieve from a submissive position (Ogden et al., 2006).

Verbatim Clinical Exchange

T: If you imagine yourself alone in your bedroom, feeling distressed, lonely, and preparing for your partner leaving you. What would you need right then, if someone that wanted the very best for you was there to support you?

P: I get an image of an elderly lady.

T: How does she look at you? How does she convey that she wants the best for you?

P: She has a warm gaze.

T: Just focus on those eyes. What does she tell you?

P: I lay my head in her lap and she just strokes my head and says “It’s ok, you are allowed to be sad.”

T: Just feel that stroke on your head and those words “It’s ok, you are allowed to be sad.” Can you notice how that affects you?

We then planned that Anna, the next time she felt a little bit upset or stressed, would retreat into her bedroom. There, instead of going into the usual imagery of being abandoned, she would do her best to bring the image of the kind elderly lady into her awareness.
Empirical Evidence

Luce & Corten (in press) discovered that individuals diagnosed with personality disorder had a significant reduction in feelings of hating themselves, less symptoms of depression and anxiety, and better functioning after practicing compassion-focused exercises for 16 weeks. In a pilot study exploring the use of compassionate images in a group of self-critical people, Gilbert & Procter (2006) demonstrated that compassion-focused therapy reduced self-criticism, shame, depression, anxiety, and stress in a chronic day hospital population. Gilbert & Irons (2005) found that using compassionate images had a calming, soothing, and caring effect on only some of the participants. Other participants found it difficult to bring to mind and fix their attention on compassionate imagery (Gilbert & Irons, 2005). The fact that exposure, even to what is supposed to be supportive, seems to be too difficult for some individuals, brings us to the next and last intervention.

Theory

Clinical observations suggest that highly self-critical individuals can find it difficult to imagine expressing their needs and receiving compassion from others. Self-hate is associated with fear of compassion for self (Gilbert et al., 2011). From both theoretical and empirical points of view, one would expect a relationship between insecure attachment and Cluster C personality. Insecure attachment, involving fear of rejection and abandonment, can be an actual fear of affiliation (Gilbert et al., 2011). Rockliff, Gilbert, McEwan, Lightman, & Glover (2008) found that high self-critics responded to imagery of receiving compassion from others with increased threat, as measured by heart-rate variability. According to Gilbert (2010), the inability to experience the benefits of compassion and affiliation implies major difficulties in internal affect regulation.

If self-criticism is seen as a mechanism of defense (McCullough et al., 2003), treating oneself with kindness would equal letting defenses down. When the seeking of closeness and support has been associated with rejection or punishment, attempts at being receptive to others’ support and care can evoke high levels of fear or other inhibitory affects. These need to be down-regulated before further exposure can continue. Experiencing previously avoided affects can also elicit levels of anxiety, shame, guilt, and pain that are felt as overwhelming and hinder continued exposure (McCullough Vaillant, 1997). It then is necessary to assist the patient in regulating affects that have an inhibitory function, “to keep the patient’s moment-to-moment experience of the conflict within manageable limits” so that exposure may proceed (McCullough Vaillant, 1997, p. 337).

During exposure through any affect-laden imagery, the therapist watches for signs indicating anxiety, shame, guilt shown in patients’ verbal report, vocal tone, and nonverbal behavior. The goal is to note whether the intensity of these affects seems to be overwhelming and thus needs to be down-regulated. The overarching principle of affect regulation is to assist the patient in shifting attention from affect-laden mental imagery to (1) the content of catastrophic cognitions the imagery evokes or to (2) exploring the physical sensations these catastrophic cognitions elicit. In addition, the patient can be assisted in regulating their affective arousal through performing specific affect-regulating movements. Such movements are described in the sensory-motor approach used in the work of traumatized patients with serious difficulties with internal affect regulation (Ogden et al., 2006).

During Anna’s exposure of anger, sadness, and compassionate imagery, she repeatedly showed signs of high discomfort and difficulties with maintaining focus on the affect-laden imagery. The focus of intervention was then shifted from continued exposure to assisting her in the regulating of the affects causing her to be overwhelmed.

Verbatim Clinical Exchange From a Therapy Segment

Focusing on Exposure for Compassionate Imagery

T: It seems hard for you to focus on the image of the elderly lady right now, is that so? What is the worst right now?

P: I don’t know. I feel weak and it’s hard to focus (voice trembling).

T: It seems your body got triggered by the image. Let’s stop for a moment and help you regulate that discomfort before we continue. Is that ok?

P: Yes (avoids eye contact).

T: If you shift your attention to your body right now, what physical sensations can you notice?

P: I feel my eyelids are heavy and my body is sort of collapsed.

T: Good. Just feel that sense of being collapsed and weak.

P: Ok.

T: Are you willing to try a little experiment?

P: Yes (a little hesitant)

T: I will do it together with you. Let’s slowly straighten our backs, so that the spine feels straight without being stiff. At the same time, let’s look slowly around the room, noticing and reminding ourselves that right now you are in my office and we are working with building the sense in you that you deserve support. What we do is a sort of mental training, and it is unusual and sometimes triggers your fear.

P: Straightens her spine, lets her gaze wander, sighs, and gradually appears more focused and calm.

We continued to explore whether Anna could notice any changes in physical activation after orienting herself in the room and establishing contact with her spine. She was able to register that she felt more awake and focused. We then decided to continue the exposure through reestablishing the compassionate imagery.

Empirical Evidence

The overall advantage of attending to patients avoidance of affect in therapy sessions are also supported by findings from Hilsenroth et al. (2003), suggesting that positive therapeutic change is associated with therapist efforts at addressing or attending to fluctuations in patient affect, that is, “avoidance of important topics and shifts in mood” (as measured by the Comparative Psychotherapy Process Scale) rather than just ignoring this in-session process. Related findings are reported by McCullough et al. (1991), who demonstrated that patients who reacted to therapist interventions with avoidance did less well in therapy.
Findings from Gaston & Ring (1992) demonstrate that therapeutic outcome is not related to affect experience in the sense of “the more affect experience the better,” but can be affected by contextual factors such as therapeutic alliance or stability of self-concept (Horowitz et al., 1984 in Diener & Hilsenroth, 2009). Individuals with Cluster C personality disorder are shame prone (Schoenleber & Berenbaum, 2010) and expect rejection and condemnation from others. Down-regulation of anxiety, shame, guilt, and pain (inhibitory affects) has been demonstrated to be related to increase in self-compassion within this diagnostic group (Schanche et al., 2011). Greenberg, Ausra, and Herrmann (2007) found that degree of productivity of processing of aroused affects, rather than arousal alone, distinguished good from poor outcome cases. For patients who struggle with self-hate and an unstable experience of self and others to benefit from the affect exposure through mental imagery, affect-regulating interventions and carefully graded exposure may be of extra importance.

Concluding Remarks

This article has presented three main interventions used in session of a therapy where the main goal of treatment was to help the patient, Anna, develop a heightened tolerance for own negative affects and an ability to treat herself with more self-compassion.

Anna did manage to gradually develop a higher awareness of and tolerance for her feeling of anger. She repeatedly disconfirmed her negative beliefs associated with anger and sadness, and could increasingly trust that having negative feelings were not the same as losing control. Being less afraid of anger and sadness also allowed her to access the information they carried about her own needs for setting limits, spending more time in taking care of her own and her partner’s needs, instead of those of others. A heightened tolerance for her own negative affects seemed to contribute to reduction in the habitual occurrence of negative self-evaluations.

When working with compassionate imagery, Anna was positively surprised by her own ability to visualize and this gave her a sense of mastery. Over time she practiced her ability to visualize a compassionate other and experienced this as helpful. She reported that she felt calmer and a little less detached. Focusing on the elderly lady’s imagined compassionate reactions to her seemed to limit negative rumination. Hence her emotions did not spiral as automatically into distress and hopelessness. Anna practiced imagining the kind lady telling her that she was allowed to feel sad, cry, and have other emotional reactions. This image thus seemed to help Anna both tolerate and regulate negative affects. After imagining the elderly supportive lady and feeling comforted by her, it was also easier for her to return to her partner and reestablish attachment to him. The combination of heightened tolerance for negative affects and improved self-compassion seemed to contribute to improving her depressive symptoms and to her ability to relate to others with less self-critical ruminations. This in turn reduced her habitual tendency to avoid social encounters.

References


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