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An Integrative Psychotherapist's Account of His Focus When Treating Self-Critical Patients

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This article presents the factors on which I focus as an integrative psychotherapist when treating self-critical patients. I first describe my personal version of psychotherapy integration. Drawing principally from Wachtel's cyclical psychodynamic model, I also incorporate existential and neurocognitive elements highlighting patients' future-oriented thinking and goal-directed action. I then relate this integrative model to the vexing clinical problem of self-criticism. Finally, I outline three types of interventions I attempt to implement in each session: (1) Multiple-Selves Analysis (MSA); (2) Behavioral Activation (BA), conceptualized integratively; and (3) use of therapist's presence.

Keywords: psychotherapy integration, self-criticism, multiple-selves analysis, behavioral activation, therapeutic presence

My clinical caseload is composed of adolescents and young adults (age range: 11–30) exhibiting severe depressive, personality, and eating disorders. The therapy tends to be long-term, the estimated median length being 3 years. As an integrative psychotherapist, I draw from Wachtel's "Cyclical Psychodynamics" model, according to which unconscious conflicts lead to psychopathology by the unwitting creation of negative social relations. The appropriate clinical response to this circumstance is an integration of insight-oriented work with active—primarily behavioral—techniques (Wachtel, 1997).

My empirical research on *self-criticism* epitomizes the principles of cyclical psychodynamics. Defined as the taking of a punitive stance toward the self when unrealistically high self-standards are not met, self-criticism constitutes a formidable risk factor in many psychopathologies (Shahar, in press). Self-critics generate life stress, and refrain from generating positive events and from eliciting social support, and they also impede relationships with therapists, thereby contributing to their own distress (Shahar, 2004, in press).

In my clinical work with self-critical adolescents and young adults, I adopt a modified version of Wachtel's cyclical psychodynamics. Drawing from existential philosophy and psychology (Shahar & Davidson, 2009) and neurocognitive research (Amati & Shallice, 2007), I emphasize patients' future-oriented and goal-directed cognitions. I posit that human suffering results primarily from the tendency to rigidly project a desired self into the future and work toward realizing what we think we should become (Shahar, Elad-Strenger, & Henrich, 2012). Such a rigid dedication might directly generate life stress and stand in the way of generating positive events and social support. I call this modified cyclical psychodynamic model "Radical Intentionalism."

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The Clinical Process: Three Key Interventions

Multiple-Selves Analyses

Theory. The notion that our self-concept is multidimensional, as opposed to being monolithic, is advanced in psychoanalysis (Bromberg, 1996), social–cognitive theory (Lysaker & Hermans, 2007), and postmodern psychology (Gergen, 2000). Underlying these theories is the realization that individuals' awareness of their self-concept multiplicity is pivotal to their well-being, because it leads to greater self-knowledge and self-acceptance.

Research. McConnell (2011) provided an excellent review of social–psychological research on multiple selves. The author emphasizes the need to conceptualize multiplicity in terms of *self-aspect* (e.g., girlfriend, daughter, Jewish, student, see McConnell, 2011, Figure 1, p. 4), rather than in terms of social identities, levels of consciousness, or ideal/aught/real self. This is important because in the clinic, the idea of multiple self-aspects may be communicated to the patient in terms of "inner voices," "different sides of yourself," and so forth. Patients find this communication both intriguing and liberating.

Linville (1987) operationalized self-concept multiplicity as "self-complexity," pertaining to the number of nonoverlapping self-aspects, where the overlap is measured in terms of attributes (a caring daughter, a diligent student, etc.). Linville (1987) has shown that elevated self-complexity buffered against stress-related depression and physical illness. However, attempts at replication have led to mixed results (Rafaeli-Mor & Steinberg, 2002).

I am unaware of *direct* evidence attesting to an efficacy of interventions in terms of increasing self-concept multiplicity. Nevertheless, *Schema Therapy*, an empirically supported, *integrative*, long-term psychotherapy for personality disorders (Young, Klosko, & Weishaar, 2003) places great emphasis on identifying various mental representations of self and others and increasing patients' awareness of these representations. This therapeutic aim is consistent with the objective of increasing multiplicity.

Another pertinent evidence-based therapy is Leslie Greenberg's *Emotion Focused Therapy* (EFT, Greenberg & Watson, 2006).

EFT uses the two-chair dialogue task (asking patients to voice an inner dialogue using one chair, and respond using another) to expose, and combat, pathological "inner voices." Recently, Ben Shahar and colleagues (2012, no relation) has espoused an open-trial of EFT for self-criticism, reporting a pre–post treatment reduction in the levels of this disposition after five to eight sessions, a reduction also maintained over a 6-month follow-up.

Application and illustration[1]. With self-critical adolescents and young adults, I strive to increase self-concept multiplicity to assist patients in (a) identifying non–self-critical self-aspects (voices), (b) become proficient in activating the latter benign aspects when distress and self-criticism are high, so as to (c) diminish the impact of the inner critic on patients' psyche.

The first step is asking patients to give a name to their self-critical self-aspect. The objective here is to make self-critical inner dialogue concrete by means of personification. Giving a name to the inner critic also delimits and demarcates it, paving the way for the identification of other voices. For instance, early in treatment, I asked *Rina*, a highly intelligent and articulated 25-year-old lawyer, to give a name to her inner critic. This went as follows:

***Golan*:**	*Obviously, you are very self-critical.*
***Rina*:**	*I am, and rightfully so.*
***Golan*:**	*Putting aside for a minute what is right and what is wrong, I'd like to ask you to do something that might be somewhat surprising. I'd like to ask you to give a name to the self-critical side, or voice, within you.*
***Rina*:**	*Hmmm* . . . (thinking for several minutes) . . . *That would be "Danny."*
***Golan*:**	(keeping silent for a few minutes) . . . *Do you know anybody by the name of Danny?*

It turned out that she had dated a guy that name years ago. He had been highly critical toward her, which had amplified her perceived self-deficiency. We then examined her dating history, realizing how important it was for her to find love, but also identifying a pattern whereby, owing to her perceived self-deficiency she fears abandonment, and attempting to prevent it, she actually precipitates it. "Danny" thus not only represents the inner critic, but also presents himself as a coherent protagonist in Rina's self-narrative, accounting for what Wachtel (after Karen Horney) describes as a vicious interpersonal cycle.

Several sessions later, I asked Rina: "Can you give names to other, non–self-critical sides of you"?. Rina replied: "There are none!". "Rina," I said, "I understand that this is how you feel. But to rise from the kind of traumas you have been experiencing since childhood, and to create yourself as a bright and accomplished person, you must possess such sides in you. It is just the case that you are not used to attending to them. Just like a dictatorship, Danny bullies everyone else into silence. We must put the bully in his place, providing others with a voice."

Although Rina and I are still grappling with identifying, describing, and naming multiple non–self-critical aspects, the mere engaging in MSA has been quite fruitful. For instance, one of the ways in which Rina used to derail promising romantic relationships was by initiating confrontations following any sign of relational difficulties, and then looking out to other male alternatives so as to "start anew." With the realization that the inner voice propelling her to seek nurturing romantic relationship represents a healthy self-aspect, Rina is increasingly attempting to give up the latter self-defeating strategy of handling romantic acrimony, instead laboring to address and resolve acrimony within the relationship.

Behavioral Activation

Theory. BA entails encouraging patients—in a systematic and structured manner—to pursue meaningful and pleasurable activities in the face of depressive anhedonia. Exemplifying the proverb "with food comes appetite," this strategy helps reinstate the bio-psychological reward system underlying operant conditioning, prompting patients to inject "positive mood" into their psyche. The theoretical underpinnings of this intervention are Skinerian-behavioral and Bandurian-social-learning ones (see Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011).

Larry Davidson and I reframed BA, as well as other active interventions such as exposure, using existential-integrative terms. Specifically, we conceptualized Participation-Engagement (*PAREN*) as a heuristic for prioritizing clinical interventions in treating comorbid, complex, and chronic psychiatric conditions (Shahar & Davidson, 2009). Inspired by Heidegger's notion of "being-in-the-world," PAREN seeks to help patients actively pursue personal projects. In my integrative treatment approach, BA is usually introduced after the identifying benign, or adaptive, self-aspects. Once these are identified, BA may be used not only to combat depressive symptoms, but also to "put the self into action," so to speak.

Research. Clearly, BA is designed to increase positive life events. Basic psychological science has attested to the protective effect of positive life events on mental health. Specifically, positive events appear to prospectively predict a reduction in distress and to buffer against the adverse effect of life stress (Shahar & Priel, 2002). As well, positive events facilitate recovery from a depressive episode (Needles & Abramson, 1990).

BA is one of the most rigorously studied interventions to date. In a series of dismantling studies comparing standard Cognitive–Behavioral Therapy (CBT) and BA, it was shown that the latter does a better job than the former in reducing depressive symptoms among clinically depressed patients (Dimidjian et al., 2011). However, to the best of my knowledge, no study has demonstrated the effect of BA on the self-concept.

Application and illustration. Superimposed upon MSA, BA has potential to quiet down self-critical ruminations, arguably because it increases the accessibility of benign or adaptive self-aspects, which are put into actual action *in-the-world*. Moreover, the direct decrease in depressive symptoms, and increase in positive affect, afforded by BA serve to reinforce benign/adaptive

[1] The submitted manuscript includes material from two current psychotherapy patients of mine. I have altered names, diagnoses, symptoms, and professions, and left sexes, genders, and the clinical process itself unaltered. Importantly, I have shared the final version with these patients, and they all signed an informed consent stipulating that they have read the material, and believe that their identifying details have been successfully concealed.

self-aspects, which in turn are propelling enjoyable and meaningful activities.

Moreover, when patients go *out-to-the-world* and experiment with novel behaviors, they experience themselves differently than the way they are used to. This, in turn, increases self-knowledge, thus facilitating psychodynamic/existential work. As Sartre (1970) phrased the idea: "It is not in some hiding-place that we will discover ourselves; it is on the road, in the town, in the midst of the crowd, a thing among things, a man among men."

Recently, Rina raised the prospect of going on a skiing vacation with two of her female friends. At that time, Rina has been recovering from a painful romantic breakup and was between jobs. Consequently, the idea of her of taking time for herself seemed to me to be a very good one. Subsequent to my endorsement of this project, Rina began backtracking. Consider the following email exchange:

***Rina*:** *"Hi Golan, I am having difficulties accepting the idea that I am going skiing for a week . . .I feel bad about spending the money. However, I don't have the guts to tell my friend I am not coming. What should I do?"*

***Golan*:** *"You should go skiing (smiling)"*

***Rina*:** *"Shouldn't I do this with a clear mind?".*

***Golan*:** *"When will this happen?"*

***Rina*:** *"It is unclear, if ever."*

***Golan*:** *"QED.*[2] *That's why I support your exploring new options and activities."*

***Rina*:** *"OK, thanks."*

Rina's experience of the trip was complex. She discovered that skiing was not to her liking, dropping out of the skiing course while her friends continued. Feeling depressed, she called her ex-boyfriend—only to be met by coldness and indifference. To top it off, she then had an unsatisfying fling with a man she met at the resort. On the positive side, she survived the week's vacation, her ability to share the painful phone call with her friends not only strengthening her relationship with them but also fortifying her desire to have close female friendships and feeling of self-efficacy with respect to forming and maintaining them. Our discussion of the fling also deepened our understanding of her yearning for love—that so easily disintegrates into a physical contact that, albeit inadvertently, keeps love at bay and summons up self-criticism.

Allowing the Therapist's Presence

Theory. As a clinician trained in relational psychoanalytic and existential-humanistic therapeutic approaches, I am favorable to the notion that patients must experience their therapist as a human being (rather than a superhero or manual). Indeed, part of the psychotherapeutic cure is the patient's sense that his therapist experiences emotions (including emotional distress) doubts, desires (personal projects), and struggles (Symington, 2012).

These are the reasons why I believe the therapist's presence is therapeutic. First, in general, glimpses into others' subjectivities encourage people to share their own. In the therapeutic space, this facilitates the patient's self-exploration. Second, experiencing the therapist as a real human being with her own struggles is likely to reduce shame and the subsequent concealment of subjectivity. Third, awareness of adaptive ways in which therapists regulate emotions might constitute a powerful modeling process. Fourth, when the therapist's presence is inconsistent with the patient's subjectivity, the consequent disagreement and impasse can facilitate inquiry into transference–countertransference exchanges (Shahar, 2004). Fifth, the therapist's presence may expedite the properly worked-through termination of treatment. Namely, I have discovered that termination often occurs best when patients perceive me as a real person with strengths and limitations.

Research. Social psychological research into self-disclosure suggests that the latter not only increases positive affect in the discloser, but also encourages target individuals' self-disclosure (Bareket-Bojmel & Shahar, 2011). As well, therapists' self-disclosure might strengthen the therapeutic alliance and appears to predict good therapeutic outcome (e.g., Barrett & Berman, 2001).

Application and illustration. When patients ask me personal questions—am I married, how many children do I have—or my opinion about events occurring in the world—I usually answer. The content of the response is usually much less relevant than patients' experience of me as a flesh-and-blood human being.

Although I do not usually *volunteer* information, there are three instances in which this may occur. First, working with patients for years instills a sense of comradeship. If the occasion arises for queries regarding my physical and mental health, I am open to sharing with the patient that I have experienced—and sometimes still do—both chronic physical illness and emotional distress. I find that this is particularly helpful for patients who also aim to be therapists (students of psychology and social work, psychiatry residents) or physicians (medical students). These young people are as sensitive as they are resourceful, and are often ashamed of their vulnerability. If they ask me, after years of therapy, "have you ever been depressed?", I will say, "I sure was. No one comes to this profession by mistake."

Second, with suicidal patients, I might disclose at the beginning of treatment my experience of the devastating consequences of parental suicide. The term "suicide survivor" is reserved for individuals one (or more) of whose loved ones have committed suicide. I happen to be a double survivor, both my biological and step-father taking the same fatal step. Over time, I discovered that disclosing my "status" could benefit the clinical process. As I administered Linehan's Reason for Living Scale—which assesses a host of reasons for not committing suicide—to yet-to-be-parent patients, some of them reported that the prospect of having children *might* act as a restraint against them harming themselves. With considerable hesitation, I noted: "You have no idea how right you are. I can tell you, with some hesitation that I am a child of a father killed by suicide, and the impact of his suicide on me is long-lasting. It is a good reason to avoid killing yourself!". The initial reaction of intense surprise usually paves the way to an enhanced therapeutic alliance.

Third, there are times in which external situations enable patients' access to my subjectivity. Israel is a very small country with a highly informal social structure. Individuals' paths frequently

[2] Quod erat demonstrandum, i.e. "I rest my case," a common expression in Israel.

cross, personal information is preamble, and one is more likely than not to know someone who knows one's therapist. Practicing in a small university town, many of my patients are students and thus are likely to know someone sitting in one of my undergraduate classes—or even one of my graduate students. "Gathering intelligence" in this context—and the current cyber world—is a mere click away.

About a year ago, I published a volume of poetry "treating" such psychological issues as self-development, depression, the state of psychoanalysis, and so forth. Some of the material is emotionally and biographically revealing. *Adam*—a very impressive young adult struggling with dysthymia and a chronic experience of being stuck ("I'm wasting my life")—incidentally stumbled upon the book (which was far from being a best seller). Having kept this information from me for many weeks, speaking about guilt in a session, he said: Yes, ***ASHMAVET***—a neologism I coined from the Hebrew words **ASHMA** (guilt) and ***MAVET*** (death).

I was too surprise to respond. Adam then said, "Yes, I did read the book." He said, "I am not sure what you meant by ***ASHMAVET***". I explained that I sought to convey how painful guilt is, particularly when one is feeling guilty about not meeting standards that one truly values. I then volunteered that such is the case, for me, with being a parent, namely that I often feel that I am falling short of being a "good enough" parent despite the fact that I hold parenting in very high regard. Such self-disclosure then enabled Adam to explore more fully his own guilt about not actualizing his outstanding intellectual potential, and to investigate, with me, the developmental and familial factors that might have derailed such self-actualization.

Conclusion

Herein, I have attempted to present the clinical process of an integrative psychotherapy inspired by Wachtel's cyclical psychodynamic model—heavily informed by "existentializing and cognitivizing"—focusing on self-criticism. Space limitations prohibit an elaboration of many aspects of this treatment (e.g., the processing of impasse) and its demarcation (e.g., suitability for older patients and other diagnoses). I nevertheless hope to have at least partially succeeded in seducing the reader into believing (i.e., convincing you) that breaking the confines of a single therapeutic approach, using MSA/BA, and enhancing the therapeutic presence is as feasible as it is beneficial.

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