A review of client self-criticism in psychotherapy.

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Abstract (English): Research on the construct of self-criticism has been gaining attention in the psychopathology and psychotherapy literature. The aims of this review are to provide an integrated theoretical and empirical understanding of client self-criticism and its implications for psychopathology and processes of self-critical change. Cognitive, emotion-focused, and psychodynamic therapy approaches are reviewed to highlight the ways in which self-criticism is addressed across different psychotherapies. Implications for treatment are put forward based upon the strengths of the different approaches in developing a self-protective and self-compassionate stance toward self-criticism. (PsycINFO Database Record (c) 2013 APA, all rights reserved)(journal abstract)

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Within the last two decades, research on the construct of self-criticism has been gaining attention in the psychopathology and psychotherapy literature. The literature indicates that self-criticism often is encountered in clients who are dealing with psychological difficulties such as depression, anxiety, eating disorders, substance abuse, personality disorders, suicide, and interpersonal problems (Bergner, 1995; Blatt, 1974; Cox, Enns, &Clara, 2002; Firestone, 1988; Gilbert &Irons, 2005). Self-criticism is thought to be a phenomenon that cuts across culture, race, class, and gender (Whelton &Henkelman, 2002). Self-critical people hold negative beliefs about themselves that either surface at different points in their lives or are maintained in a consistent manner across time (Blatt, 1974; Whelton, Paulson &Marusiak, 2007). Although self-criticism may be experienced universally, it also can contain differences in its form, severity, and consequences for each individual (Whelton &Henkelman, 2002). The focus of this paper is on self-criticism as *a conscious evaluation of oneself that can be a healthy and reflexive behavior, but also can have harmful effects and consequences for an individual.* This definition was drawn from psychotherapy researchers' writings on self-criticism and positions the meaning of self-criticism on a continuum of healthy to maladaptive aspects of experience (Blatt, 1974; Chang, 2008; Gilbert &Irons, 2005; Shahar, 2001; Whelton &Greenberg, 2005).

The Role of Self-Criticism in Psychopathology and Psychotherapy

The examination of self-criticism in psychopathology is focused upon the literature related to depression and perfectionism, because depression and perfectionism have been theorized as being characterized by strong self-critical responses. The review of the psychotherapy literature documents the relationship between self-criticism and therapy alliance and outcome.

Self-Critical Processes and Depression

Self-criticism is most often described in the literature as a dimension of depressive vulnerability or a component of depression (Blatt, Quinlan, Chevron, McDonald, &Zuroff, 1982; Carver &Ganellen, 1983; Gilbert, Clarke, Hempel, Miles, &Irons, 2004; Klein, Harding, Taylor, &Dickstein, 1988; Rector, Bagby, Segal, Joffe, &Lefitt,

2000; Shahar, 2001; Whelton &Greenberg, 2005). However, it is important to note that self-criticism is not exclusive to depression. For instance, self-criticism has been found to be a predictor of eating-disorder dimensions (Fenning et al., 2008) as well as the outcome of borderline personality treatments (Meares, Gerull, Stevenson, &Korner, 2011) and is a major component of anxiety and personality-focused research (Dunkley, Zuroff, &Blankstein, 2006; Frost, Heimberg, Holt, Mattia, &Neubauer, 1993; Hewitt &Flett, 1991; Shahar, Blatt, Zuroff, &Pilkonis, 2003, Shahar, Blatt, Zuroff, Krupnick, &Sotsky, 2004).

Much of the research relating self-criticism to depression originated from Sidney J. Blatt's psychodynamic conceptualization of depression (1974). Subsequent research has found that clinically depressed populations exhibit higher levels of self-criticism than normal controls (Klein et al., 1988; Luyten et al. (2007). In addition, self-criticism (and trait dependency) also has been associated with the recurrence of depressive episodes (Mongrain &Leather, 2006). Some researchers also have begun to examine the forms of rumination (i.e., brooding) that are most linked to suicidality (O'Connor &Noyce, 2008).

Self-Critical Perfectionism and Coping

Although perfectionism can have positive consequences for individuals, perfectionistic behavior can be harmful, especially when those behaviors are accompanied by unrelenting self-criticism and negative self-evaluation. Although there is some consensus in the literature on the development of maladaptive perfectionism (Shafran &Mansell, 2001), three main dimensional models of perfectionism have been most widely used thus far, two of which have the identical name; the Multidimensional Perfectionism Scale as developed by (a) Frost and colleagues (1990), and by (b) Hewitt and Flett (1991), and (c) *The Almost Perfect Scale* (Slaney &Johnson, 1992; Slaney, Rice, Mobley, Trippi, &Ashby, 2001). Multiple dimensions of perfectionism are assessed across these measures, such as excessive concern over making mistakes, high personal standards, a need for order and organization, and self- versus other-oriented perfectionism.

Dunkley and Kyparissis (2008) conceptualized self-critical perfectionism as "constant and harsh self-scrutiny" and "concerns about others' criticisms" (p. 1296). They found that individuals that had higher levels of self-critical perfectionism described themselves as having feelings of guilt, sadness, hopelessness, loneliness, and low positive emotion. They also reported being sensitive to ridicule and expressed being cynical and skeptical. Dunkley, Zuroff, and Blankstein (2006) found that self-critical components of perfectionism significantly predicted daily stress, avoidant coping mechanisms, low-perceived social support, negative affect, and low positive affect. Other correlational research also has provided results consistent with these findings too (Flett, Hewitt, Blankstein, &Gray, 1998; Gilbert, Baldwin, Irons, Baccus, &Palmer, 2006). Self-critical perfectionism has also been related to maladaptive coping (i.e., self-critical perfectionists responded to stressful situations with self-blame, engaged in other tasks rather than the task at hand, and used fewer problem-oriented strategies to cope with stress). The findings from the above studies suggest that though perfectionist striving can have positive outcomes for performance, accompanying self-criticism can hamper individuals' sense of efficacy and increase self-blame, especially after a perceived stressful or failed experience.

Accordingly, perfectionism and depression can be intertwined. Research from the United States Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health Treatment of Depression Collaborative Research Program demonstrated that perfectionism was negatively related to outcome (Blatt, Zuroff, Quinlan, &Pilkonis, 1996; Krupnick et al., 1996). Zuroff et al. (2000) examined the relationships among perfectionism, perceived relationship quality, and the therapeutic alliance. The results

indicated that the patient contribution to the alliance and the perceived quality of the therapeutic relationship were independent predictors of outcome and perfectionistic patients showed smaller increases in the patient-alliance factor over the course of treatment. Furthermore, the negative relation between perfectionism and outcome was mediated by perfectionistic patients' failure to develop stronger therapeutic alliances.
The research reviewed in this section suggests that clients with disorders associated with self-criticism are likely to have difficulty connecting with others and to experience psychological distress. The next section reviews research on the relationship of self-criticism itself to psychotherapy alliance and treatment outcome.

The Relationship Between Self-Criticism and Therapeutic Alliance and Outcome

The therapeutic alliance refers to the collaborative aspect of the working relationship between client and therapist, in which they join together to negotiate the tasks and goals of therapy (Horvath &Symonds, 1991). Psychotherapy research has documented the importance of the working alliance and its contribution to psychotherapy process and outcome (Ackerman &Hilsenroth, 2001). Recent efforts at examining the effects of self-criticism on therapeutic alliance suggest that self-criticism might act to impair the alliance.
Whelton et al. (2007) examined the relationship between self-criticism and the therapeutic alliance in 169 clients attending a community clinic. Self-criticism was positively correlated with clients' hostile mood state and negatively correlated with their ratings of positive affect (as measured by the Visual Analogue Scale (VAS), Albersnagel, 1988), even at 9 and 12 weeks of counseling, respectively. Client ratings from the Working Alliance Inventory (Horvath &Symonds, 1991) were negatively correlated with self-criticism, suggesting that the greater an individual's level of self-criticism, the more negatively they rated their relationship with the therapist. When they controlled for the effects of hostility and positive affect, self-criticism no longer predicted working alliance, suggesting that levels of hostility and positive affect accounted for the working alliance scores at certain sessions.
Janzen (2007) conducted a qualitative analysis using the *interpersonal process recall* method (Kagan, 1975) to examine self-critical processes that clients engage in during therapy. An in-depth phenomenological analysis revealed that participants constantly evaluated therapists and their therapy experiences. They did not easily receive compliments from others including their therapists, and tended to minimize their needs and accomplishments in therapy. Trust also was an obstacle in the therapeutic relationship, and the need for approval from therapists prevented them from being open and disclosing. The study suggested that participants engaged in a meta-evaluative therapeutic process in which they evaluated each other's connection and evaluation of the relationship as they interacted. What participants found most helpful, however, was feeling safe and understood by their therapists, and therapist disclosures about being invested in the therapeutic relationship. Studies reviewed in this section suggest that close attention to the psychotherapy relationship is particularly important for self-critical clients.

The Treatment of Self-Criticism Across Approaches to Psychotherapy

Psychodynamic Therapies

Mechanisms of self-critical change

Self-criticism has origins in psychoanalytic frameworks and was developed within a psychoanalytic model of

depression. For example, Freud described self-criticism in the form of moralistic superego attacks on the ego (Freud, 1917), and Justin Aronfreed (1964), a psychoanalytic thinker, related self-criticism to internalized childhood experiences of punishment. Object-relations scholars have a history of examining self-hatred through the lens of internalized parent–child relationships (see Scharff &Tsigounis, 2003).

Blatt's (1974) work on trait-based subtypes of depression was an important marker in describing individuals with self-critical personalities. The first subtype of "anaclitic" or dependent depression included interpersonal concerns such as helplessness, fear of loss or abandonment, and the need to be cared for, loved, and protected. The second subtype of "introjective" or self-critical depression was thought to be characterized by feelings of inferiority, guilt, and a sense of failure to live up to one's expectations and standards (Blatt et al., 1982). Blatt and Zuroff (1992) described self-critical individuals as constantly striving for high achievement and perfection, and excessively concerned about disapproval, and rejection from others. Shahar (2001) discussed the role of shame in introjective (self-critical) depression and suggested that introjective individuals are sensitive to perfectionistic messages that can be conveyed by their parents and by larger society. The author goes on to state that perfectionistic individuals may see achievement and striving for perfection as a solution for their shame and inadequacy, but in reality, the cycle of holding unrealistic standards for oneself can, in fact, exacerbate their lack of satisfaction with their performance and lead to further self-degradation in the form of depression, eating disorders, and even suicide.

Shahar (2004) has discussed ways in which clients might deal with their self-criticism by activating their therapists' self-criticism or inadequacy. He described action theory as the understanding that some interactional styles (e.g., self-criticism) use behaviors (e.g., criticizing others) that generate similar reactions in others (e.g., introjected self-criticism) and create conditions that, in turn, maintain their interaction styles (e.g., rejection). Psychodynamic approaches therefore have been invaluable in not only initially developing a focus on self-criticism, but in the development of a contemporary theoretical and relational framework for understanding self-criticism.

Treating self-criticism based on psychodynamic theory: Critical voices and dialogical narratives

A number of different approaches to working with self-criticism have developed from psychodynamic approaches. This focus is evident in the work of Robert Firestone, a leading psychoanalytic theorist on self-destructive processes and developer of the "voice therapy" approach to treating self-criticism (Firestone, 1988). According to Firestone, change occurs when the manner in which one processes self-critical thoughts shifts (i.e., from an inwardly directed process of negative ruminations, to an external, free, and unrepressed voice). Drawing on findings from research in attachment and interpersonal neurobiology, voice-therapy techniques are based on separation theory, which integrates psychodynamic and existential perspectives in explaining how psychological defenses formed very early in life are reinforced as children develop an understanding of personal mortality.

Voice therapy accesses clients' core maladaptive beliefs in the presence of emotional arousal. The core therapeutic technique of voice therapy is that clients learn to verbalize their critical thoughts in the second person, as though another person were talking to them. According to this approach, shifting to this second person format brings to the surface the emotional content of self-critical thoughts and allows for separation between the clients' rationales and their internalized self-critical attitudes. This process allows the client to safely identify their sources of self-criticism in painful childhood experiences or trauma. This developmental

perspective can lead to exploring which behaviors (e.g., addiction, anxiety) may be controlled or exacerbated by self-critical thoughts.

Layne, Porcerelli, and Shahar (2006) have described Blatt's depression subtypes and called for combining psychodynamic and cognitive approaches to working with self-critical clients. In a client who demonstrated both anaclitic and introjective forms of depression, Layne et al. (2006) presented a case study of a treatment for self-criticism that described the client's process of integrating positive ideas into her self-concept over the course of treatment.

Across these approaches, the function of having clients recognize and verbalize negative and internalized attitudes and their origins appears to render them less powerful and permit a more positive self-evaluation to be integrated. There is a large volume of research on the effectiveness of psychodynamic psychotherapies in general (e.g., Jakobsen, Hansen, Simonsen, &Gludd, 2012), and future research on use of these specific therapeutic interventions to treat self-criticism will continue to develop this field.

Cognitive Therapy

Mechanisms of self-critical change

Cognitive therapy grew from Beck's suspension of psychoanalytic theory and behavioral theories (Leahy, 2006) and creating a new framework that outlined therapy procedures to change cognitions (Beck, Rush, Shaw, &Emery, 1979; Rush, Beck, Kovacs, &Hollon, 1977). Beck (1967) defined cognitive schemas as "relatively stable cognitive patterns" that are used consistently to interpret life situations (p. 7). Young (1999) expanded on Beck's ideas and identified a set of 18 maladaptive schemas, which have found some support in subsequent research (Schmidt &Joiner, 2004). Some of these early maladaptive schemas can promote self-critical states, such as *unrelenting standards, hypercriticalness,* and *punitiveness.* The change mechanisms involved in cognitive therapy center around understanding and changing dysfunctional or self-critical thoughts or schemas that individuals carry with them into different situations.

Treating self-criticism: Restructuring and reattribution

Two commonly used examples of interventions to treat self-criticism are modifying maladaptive schemas through *cognitive restructuring* and *reattribution* (Beck et al., 1979; DeRubeis et al., 1990). In the first intervention, cognitions are restructured by identifying and testing clients' maladaptive schemas or beliefs. Clients are taught to regard their self-criticisms as hypothetical ideas that must be tested in session. Beck employed Socratic questioning by asking clients questions to retrieve information to challenge depressed thoughts. For example, if a client says "I never do anything right" the therapist might respond by asking the client to recall a recent accomplishment. Cognitive restructuring may be practiced through a variety of techniques such as role playing, the use of imagery and reality testing to promote a more adaptive and realistic self-view (Beck et al., 1979). This conceptualization has been reworked in Beck's later work (1996) on mode deactivation therapy (MDT), in which schemas are not viewed as irrational, but as core beliefs that serve a self-protective function. In either case, once self-critical thoughts are identified, clients are encouraged to take on a more objective approach in countering their self-defeating thoughts.

The second intervention, reattribution, is commonly used as a technique in working with self-critical clients because of their tendency to frequently hold themselves responsible for negative outcomes that are out of their

control. The goal here is to direct clients to assign the appropriate amount of responsibility to themselves but also to external factors that may have contributed to the clients' difficulties. The therapist also may choose to counter the clients' cognitions by evaluating the "facts" or "truths" about the event that resulted in self-criticism. This technique also has been labeled "de-responsibilitizing" (Beck et al., 1979).

Supporting research

There is a good deal of evidence that cognitive approaches in general are efficacious in treating disorders associated with self-criticism, such as depression (e.g., Robinson, Berman, &Neimeyer, 1990). De Oliveira et al. (2012) proposed a procedure for cognitive restructuring, which focused on a form of self-criticism called the trial-based thought record (TBTR), and which was designed to make patients aware of their self-critical core beliefs. Patients in the study (N = 166) were submitted to a simulation of a legal trial and their endorsements of negative core beliefs and corresponding emotions were examined. Therapists (N = 32) at different levels of training in cognitive therapy and TBTR participated in the study. Results indicated significant reductions in patients' adherence to core self-critical beliefs as well as intensity in corresponding emotions. Although the intervention was conducted on just one session of psychotherapy, the present study also compared the empty-chair approach to TBTR. No significant differences were found between approaches, and authors suggested that both methods seem to work well, significantly reducing self-criticism to a very low level.

Using a different approach, Gilbert et al. (2004) analyzed self-critical individuals' responses to failure from a schematic and cognitive-interpersonal perspective (Baldwin, 1992; Beck, 1967) via his compassionate mind training (CMT) approach. Their recent work (2006) was based on the assumption that self-criticism and self-reassurance are learned interpersonal scripts (i.e., one relates to the self in ways others have related to the self). They used a self-imagery task with undergraduate students (N = 197) that examined the ease with which participants could access and generate images related to self-criticism and self-reassurance after an imagined experience of failure. Self-criticism was associated with ease and clarity in generating hostile self-images, while self-reassurance was associated with ease in generating supportive self-images. They found that the power and anger associated with the hostile images were significantly related to self-criticism and depression. Results also indicated that difficulties in generating compassionate images could contribute to feeling depressed. They suggested that generating compassionate imagery can provide a bridge between cognitive and emotional processes in therapy, especially after a perceived failure.

Emotion-Focused Therapy

Mechanisms of self-critical change

Process-experiential theory (PE)/emotion-focused therapy (EFT) is an empirically supported approach that integrates client-centered and gestalt therapies, and is based within a dialectical-constructivist philosophy. When polar parts of the self are brought into contact with each other, change can occur by developing an awareness of the differences between these opposing parts. The goal in therapy is to help clients arrive at a more integrated experience, rather than maintaining a constant "split" between the two parts. The concepts and interventions in this orientation were developed in the 1970s and the key proponents of this theory and therapy were Leslie S. Greenberg, Laura N. Rice, Sue Johnson, and Robert Elliott. Process-experiential theory holds that emotions are essentially adaptive for the regulation of behavior and formation of attachment but become

maladaptive as a result of past traumas or learning inappropriate styles of coping with and regulating painful emotions (Elliott, Watson, Goldman, &Greenberg, 2004). For example, some self-critical clients may have developed the maladaptive emotion of shame in response to being belittled during their development. In this orientation, distinctions have been made between *primary* and *secondary* emotional responses (Greenberg &Safran, 1987; Greenberg, Rice, &Elliott, 1993). Primary emotions are defined as "here-and-now, immediate, direct responses to situations," such as sadness in relation to loss, or fear in response to threat (Greenberg et al., 1993, p.75). Secondary emotions are more reactive in nature and obstruct the primary emotion process, such as expressing anger in response to underlying fear or sadness.

Therapeutic change also can be produced through activating "emotional schemes," described as "nonconscious mental structures" (Greenberg et al., 1993, p. 66) that can determine how individuals experience and perceive themselves in relation to the world. They are different from cognitive schemas in that they are largely affective and nonverbal modes of experiencing (Greenberg, Watson, &Goldman, 1998). According to Greenberg and Paivio (1997), these emotion schemes are automatically produced and can be based on past emotional experiences or emotion-based memories developed from birth (e.g., immediate anger at feeling violated or fearful when faced with threat). These emotion schemes can generate dysfunctional responses in clients, especially when schemes activate damaging or traumatic aspects of experience. This model holds that emotions themselves are not maladaptive. Instead, the anxiety or depression that develops from anticipation that a certain need will not be met or that particular emotions should be avoided, can lead to maladaptive coping. The negative affect or feeling (such as contempt or disgust for the self) that accompanies an individual's self-criticism is considered to be the main factor in maintaining self-critical beliefs in this model.

Treating self-criticism in EFT: The two-chair dialogue

The main intervention used to treat self-criticism within the EFT model is the *two-chair dialogue* exercise that is designed to respond to self-criticism or a *self-critical split*. The task of the therapist is to structure a dialogue between the self-critical aspects of the client, or the self-critic, and the part that is being criticized, referred to as the self (Greenberg et al., 1993, p. 189). The intervention typically is engaged in response to clients' verbal statements or markers of self-criticism in the course of a session such as "I'm a failure" or "I should work harder" (Greenberg et al., p. 189).

The resolution of self-criticism occurs in three main stages (Greenberg et al., 1993, p. 198). First, *opposition*: Once a marker that is, the self-critical split has been identified, the therapist helps clarify what the two opposing sides of the conflict are. Here, the therapist's goal is to heighten each side of the conflict by directing the critic to verbalize specific criticisms (e.g., "You are a coward," verses a global statement such as "You are bad") and directing the self to describe their impact and/or protest. With this verbalization, clients can recognize the intensity and harshness with which they evaluate themselves. Second, in the next stage of *contact*, the crux of the work involves engaging the client's emotions on both sides of the split. The therapist encourages the client to stay with and elaborate on difficult feelings, rather than move away from them. This differentiation of feelings generates new meaning-making as well as identifying new needs that emerge from the differentiated feelings (e.g., I need to seek support when I feel frightened and vulnerable). The third and final stage of *integration* occurs when the critic and the self have expressed their feelings and associated needs, and the critic begins to soften or become more self-soothing, and less evaluative, harsh, or blaming. The initial blaming critic voice may be replaced by concern or fear (e.g., the critic's initial harsh statement toward the self of "You are a failure" may

soften to “I am scared that I will be hurt if I fail”). A process of negotiation of needs and wants takes place between the two sides in this manner, until a more unified perspective is reached between the self and the critic. Notably, the goal of treatment is not to eliminate self-criticism, as self-criticism can have adaptive aspects that clients wish to maintain, but to help clients develop a resolution that is useful for them.

Supporting research

Research on experiential therapies generally has shown positive changes in clients’ emotional states and therapy outcome (Adams &Greenberg, 1996; Korman, 1998; Greenberg, Elliott, Watson, &Bohart, 2001; Elliott, Greenberg, &Lietaer, 2004). For example, Elliott, Greenberg et al. (2004) meta-analysis reported large effect sizes for process-experiential therapy, including a pre–post effect size of 1.26 (*N* = 18 studies), which indicated that the average treated client in those studies had positively moved one and a quarter standard deviations during therapy. Additionally, 46 studies comparing cognitive–behavioral therapies to experiential therapies were found to be clinically equivalent (Elliott, Greenberg et al. 2004).

Ben Shahar et al. (2012) conducted a one-session pilot study to investigate the efficacy of a two-chair self-critical split task on self-criticism, self-compassion, and the ability to self-reassure in times of stress, as well as on depressive and anxiety symptoms among highly self-critical clients (*N* = 9). Results indicated that the intervention was associated with significant increases in self-compassion and self-reassuring behaviors, and significant reductions in self-criticism, depressive symptoms and anxiety symptoms, as evidenced by moderate to large effect sizes. These studies, although preliminary, have implications for Paul Gilbert’s (2000) conceptualization of self-criticism where in his view, constant practice or training clients in self-compassion is necessary in defending oneself against self-criticism because self-soothing has been an underdeveloped practice in self-critical clients (Gilbert &Irons, 2005).

Like Ben Shahar et al. (2012); Whelton and Greenberg (2005) examined the immediate emotional effects of self-criticism among psychology undergraduates in a large metropolitan university in Canada by using a one-session intervention (*N* = 60). Participants were divided into three groups whose self-ratings on the Depressive Experiences Questionnaire (DEQ) indicated high self-criticism (*n* = 30), high dependency (*n* = 15), and the third group combined both low dependency and low self-criticism scores (*n* = 15). They were asked to recall an experience of failure (to induce a dysphoric mood), and then criticize themselves and respond to their criticisms via an empty-chair technique. The high self-critics were judged as being significantly more contemptuous than the controls in their self-criticisms and also were less resilient to their criticisms. Also, they experienced more sadness and shame in response to the criticisms and had difficulties with verbalizing confident or assertive responses to their self-critics.

These findings relate to Kelly, Zuroff, and Shapira’s (2008) research on self-criticism, self-compassion, and resisting self-critical attacks. They found that experiences of shame were highly prevalent among self-critics in a nonclinical sample (*N* = 75). They developed two self-help interventions based on Gilbert and Irons’ (2005) compassionate mind training approach, and incorporated chair work from Gestalt and emotion-focused therapies (Greenberg et al., 1990; Perls et al., 1951). Participants were randomly assigned to (a) a control condition, (b) a self-soothing intervention that invited participants to engage in compassionate, nurturing, and reassuring imagery and self-talk, and (c) an attack-resisting intervention that asked participants to engage in strong, resilient, and retaliating imagery and self-talk. They found that over a 2-week period, the attack-resisting condition lowered ratings of depression significantly more than the control condition, as well as lowered ratings

more for high than for low self-critics. Individuals in both intervention groups showed greater and significant reductions in shame experiences than controls across time.

In addition, other researchers who have studied emotional processes (Leary, Tate, Adams, Allen, &Hancock, 2007) found that self-compassion was negatively related to negative emotion, specifically, anxiety, sadness, and self-conscious emotions, such as embarrassment or guilt. These results suggested the importance of helping clients develop empathy and self-compassion (Chang, 2008; Gilbert &Irons, 2005; Whelton &Greenberg, 2005), as well as build emotional assertiveness or resilience (Greenberg et al., 1998) against the harsh and controlling aspects of the self-critic. The findings in this section speak to the growing importance of addressing self-criticism across treatment modalities. Interventions across therapy orientations tend to address self-criticism through multiple methods, such as building empathy and self-compassion, shifting intensity of core beliefs, evoking primary emotion, and rescripting self-critical beliefs.

Integrating Understandings of Self-Criticism

Through this review, the following principles have been identified as common across treatments for self-criticism. These might serve as useful foundations for an understanding of common factors or processes that address self-criticisms or for the development of integrative treatments for self-critical clients. As self-criticism has been associated with negative outcomes in the psychotherapy literature reviewed (e.g., Marshall, Zuroff, McBride, &Bagby, 2008; Rector et al., 2000), it is important to consider ways to deal with self-criticism when it emerges in therapy.

Self-criticism can be a harmful force in clients' lives

Excessive self-criticism has been viewed as harmful across orientations, despite its adaptive aspects. It is prominently situated as an important predictor of depression within theoretical models of depression that have discussed the role of self-criticism (Beck et al., 1979; Greenberg, Watson, &Goldman, 1998; Shahar, 2001). It is unclear how self-criticism would be conceptualized in other client pathology or nonclinical populations, although some research (Luyten et al., 2007; Whelton &Henkleman, 2002) has suggested that self-criticism can be harmful even within normal populations.

Client self-criticism is maintained due to a subconscious maladaptive coping response

Self-criticism is maintained when clients practice automatic and maladaptive ways of reacting to and coping with self-criticism. For example, in cognitive therapy, certain dysfunctional thought patterns such as brooding or overgeneralization of failures were thought to carry forward one's self-critical and depressive thinking (Beck et al., 1979; O'Connor &Noyce, 2008; Miranda &Nolen-Hoeksema, 2007). In EFT, clients maintained their self-criticisms by inappropriately regulating the emotions related to them and using secondary emotional processing or avoidance. For example, a client who fears intimacy may react with anger in response to her partner's attempts at affection. Psychodynamics conceptualize self-criticism as maintained through internalized relationships (Scharff &Tsigounis, 2003), disruptions of personal relationships (i.e., object loss, Shahar, 2001), or maladaptive defense mechanisms. These psychotherapy orientations all share a sense that self-criticism becomes automated and may need to be drawn into awareness before its full extent can be recognized by clients.

Interventions centered on awareness of both the content and process of self-criticism

Clients' awareness about self-criticism was regarded as an important focus for the three orientations (i.e., cognitive, psychodynamic, and emotion-focused therapies). Promoting awareness might take different forms in each orientation (such as disputing self-critical thoughts, exploring transference, or chair-work) and eliciting clients' self-criticisms was important so that therapists and clients could better understand the problematic ways in which clients were relating to themselves. This goal furthered the therapeutic relationship, in which therapists could connect with clients' harsh views of themselves, and use the alliance as a tool to teach adaptive ways of relating to the self. Across these approaches, the clients became aware not only of the specific self-criticisms that they harbored, but also the processes and roots of self-criticism. This awareness generated the possibility for changing both the content and the nature of self-criticism.

Resolving self-criticism by strengthening the self (not eradicating self-criticism)

Across the orientations explored, self-criticism was resolved by changing the manner in which it was being understood and processed by clients. For example, a strength of cognitive therapy is to teach clients ways in which they could displace their self-criticisms by being assertive and assigning blame to external rather than internal factors. Psychodynamic approaches can act to help clients become aware of unconscious self-criticism so they can integrate more positive understandings of themselves (e.g., Layne, Porcerelli, &Shahar, 2006). In EFT, clients' chairing often shapes a kinder, self-protective critic that could be useful to their growth rather than harmful, and a stronger, more confident self (e.g., Greenberg, Rice, &Elliott, 1993). Although the three orientations moved their clients away from the damaging and self-destructive to more constructive and less harsh perspectives of self-criticism, this did not mean eliminating all self-criticism, but rather keeping healthier forms of self-criticism and maintaining adaptive responses to self-criticism.

Resolution of self-criticism: Externalizing the self-position

The treatment findings and theoretical literature suggested that therapists guided clients toward modifying their position in relation to their self-critic or self-criticism (e.g., from a self-destructive to a self-protective critic in EFT, from an internal to an external voice in psychodynamic therapy, or from an internalized self-blame position to a more externalized stance in cognitive therapy). In the review of the intervention literature, the orientations engaged clients in this process of explicitly exploring their self-critical thoughts and emotions (e.g., through guided discovery in cognitive therapy, the exploration of the critical voice in psychodynamic therapy, and the self-critical two-chair dialogue interventions in EFT). Through this outwardly exploratory process, clients may begin to feel more empowered to effectively deal with their criticisms.

The demonstration of empathy and compassion

In the studies on alliance, clients with high levels of self-criticism and perfectionism that were found in early and later stages of treatment tended to have alliance difficulties in therapy Whelton et al., 2007; Zuroff et al., 2000). In addition, clients reported that negative emotions of fear and shame prevented them from disclosing what they were distressed about in therapy (Janzen, 2007). With these findings, researchers suggested that establishing and maintaining empathetic bonds with the client can be important in gaining clients' trust as well as creating an environment of safety for client disclosure. Empathy can provide a direct learning or "corrective relational experience" to clients (Greenberg et al., 2001, p. 382), and the alliance between client and therapist may help

strengthen the self. Using EFT, empathy as an intervention can be validating and reassuring to self-critical clients, especially when clients struggle with intense negative emotions (e.g., shame). In cognitive therapy, empathy serves to further treatment goals and to understand clients' core beliefs and thought patterns. Metacommunication with clients about their self-critical processes in therapy can help gauge how clients perceive themselves and the therapist, as well as better understand their needs in therapy (e.g., asking clients how they may be holding back issues in therapy for fear of failure, shame, and disappointment). In psychodynamic approaches, exploring transference patterns could help clients understand how their self-criticism functions in the context of their relationships.

Enhancing client agency through increasing clients' self-compassion and assertiveness

In this review, the three orientations tried to enhance clients' sense of agency to deal with self-criticism in their lives. They attempted to extend and restructure the ways in which clients typically related to themselves (e.g., from self-attacking to self-nurturing or self-enhancing). This conceptualization is apt, given that the findings across the psychopathology and psychotherapy literature on self-criticism, which suggest that self-critical clients tend to experience a sense of defeat, inferiority, and self-blame around stress, failure, and negative emotion (Dunkley et al., 2006; Flett, Hewett, Blankstein, &Gray, 1998). In EFT, therapists dealt with this failed self by helping clients adopt a more compassionate view of themselves and their perceived failures and stresses (e.g., via softening the critic). In cognitive therapy, the focus was on harnessing clients' sense of assertiveness (e.g., via disputing cognitions or increasing assertiveness by not giving into ruminative cognitive styles). In psychodynamic approaches, therapists helped clients build up self-esteem (e.g., by drawing their attention to their strengths and accomplishments).

Preparing therapists to tolerate criticism

In this review, the literature suggested that clients with high levels of self-criticism predicted a poorer response to psychotherapy, feelings of contempt when they did not meet their high and unattainable standards, and were resistant to acknowledging treatment successes (Gilbert et al., 2006; Janzen, 2007; Rector et al., 2000).
As a result, therapists may need to develop processes to deal with their own self-criticisms. Therapists' abilities and comfort levels in dealing with client self-criticism may be, in part, a function of their own self-critical attitudes, beliefs, and experiences (Shahar, 2001; Vane, 2004). In addition, tolerating, accepting, and connecting with difficult and intense negative emotions from self-critical clients also can be a fruitful area of exploration for therapists (Greenberg, Rice, &Elliot, 1993). And exploring countertransferential reactions could provide therapists the opportunity to recognize and manage such responses. Given these intra- and interpersonal difficulties, therapists also might benefit from exploring clients' concerns at the start of therapy, as well as addressing clients' unrealistic expectations of success.

A Brief Conclusion

Suggestions for future research to improve the breadth and depth of research in this area include: (a) Research on how self-criticism relates to psychological phenomena other than depression, perhaps in diagnostic categories such as anxiety, substance abuse, and self-image issues; (b) study of the adaptive functions of self-criticism and the processes involved in less severe self-criticism; (c) the development of operational and distinct definitions of self-criticism that are distinct from depression and perfectionism, perhaps based upon factor-

analytic research; (d) research on cultural factors and self-criticism to enrich our understanding of the scope of self-criticism—for instance, explicitly communicated self-criticism (i.e., self-critical attitudes directly expressed to family and friends) may serve the purpose of receiving others' care, compassion and support in Japanese culture (Kitayama &Markus, 2000). And given the link between depression and gender, it may help to study self-critical processes in women (Luyten et al., 2006; Wu and Anthony, 2000). (e) Future research also could continue to advance the revival of psychodynamic approaches to the treatment of self-criticism and integrate the different approaches to working with self-criticism.

This paper has identified commonalities that might act as core principles for treatment across psychotherapy approaches or integrations, with a focus on self-criticism. Self-criticism appeared to be experienced with intense negative affect, as well as disturbing and ruminative thoughts related to the self, both of which can be daunting for therapists to confront. This understanding can provide direction for continued research and can provide graduate therapists in training treatment guidelines for how to best treat self-critical clients in psychotherapy.

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