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UNDERSTANDING SELF-CRITICISM FROM PERSONAL AND PROFESSIONAL PERSPECTIVES

SECTION A: A THEMATIC SYNTHESIS OF QUALITATIVE STUDIES EXPLORING INDIVIDUALS' EXPERIENCES OF SELF-CRITICISM

Word Count: 7999 (156)

SECTION B: HOW DO UK CLINICAL PSYCHOLOGISTS UNDERSTAND SELF-CRITICISM IN PRACTICE? A GROUNDED THEORY STUDY

Word Count: 7954 (282)

Overall word count: 15953 (438)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

DECEMBER 2022 (March 2023)

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I would like to give a huge thank you to everyone who took part in the study. It would not have been possible without you.

I am so grateful to the wonderful Dr Sue Holttum and Dr Emma Smith for your time and support supervising this project. Thank you so much.

I am thankful to my Nan, my partner Nathan, my family and fantastic friends for their love and support throughout this long journey. I could not have done this without you.

Summary of Major Research Project

Section A:

This review aimed to investigate individuals' experiences of self-criticism. A systematic literature search was conducted. Eight qualitative studies were identified, and their quality was assessed. Thematic synthesis was used to identify four central themes: Origins and triggers of self-criticism past and present; qualities of self-criticism as harsh and distorting; known and unknown impacts of self-criticism; and self-criticism as a survival mechanism, achievement motivator or moralising force. Twelve subthemes were also identified. The review outlined clinical and research implications of findings.

Section B:

This study aimed to investigate how UK based clinical psychologists understand and work with people who are highly self-critical in practice. Ten psychologists were recruited via social media and interviewed. Data was analysed using grounded theory. Two contextual categories were identified: Self-criticism as common and yet exists in a "blind-spot" in mental health; and psychologists' own experiences of self-criticism and difference. Three main categories were identified: Understanding client's personal and/or shared critics; recognising the "size" and "influence"; and working with the "clinical gut" to integrate models and ideas. Study limitations were discussed, along with clinical and research recommendations.

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Section B

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SECTION A:

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Abstract

Purpose: Self-criticism is considered a transdiagnostic component in mental health which can significantly impact individuals' psychological distress and wellbeing. This review aimed to identify and synthesise studies which investigate individuals' experiences of self-criticism.

Methods: A systematic literature search of six online databases yielded eight qualitative studies meeting inclusion criteria. Studies were reviewed using a quality assessment tool and key methodological concerns were discussed. Studies were synthesised using thematic synthesis procedures.

Results: Four central themes and twelve subthemes were identified: Origins and triggers of self-criticism past and present (childhood experiences, hypercritical environments, health, standards, triggers); qualities of self-criticism as harsh and distorting (constant harsh attacks, automatic versus deliberate, distorting reality); known and unknown impacts of self-criticism (known negative impacts, becoming aware of previously unknown impacts, and strategies to manage); and self-criticism as a survival mechanism, achievement motivator or moralising force (protects me, keeps me safe and motivates me, and misconceptions about self-compassion and fear of being without self-criticism).

Conclusions: Implications and recommendations for future research were discussed, including how experiences of self-criticism map onto existing outcome measures, and the importance of investigating experiences of self-criticism for individuals with different backgrounds.

Keywords: Self-criticism, experiences, transdiagnostic, qualitative, thematic synthesis

1. Introduction

1.1. Defining self-criticism

Self-criticism is considered a transdiagnostic component in mental health which can significantly affect psychological distress and wellbeing, occurring beyond diagnostic categorisations of mental health (Harvey et al., 2004; Kannan & Levitt, 2013; Schanche, 2013).

Self-criticism has been conceptualised in many different ways within the literature. From a neurophysiological perspective, self-criticism has been associated with different neural activity in different brain regions compared with self-reassurance and self-compassion (Longe et al., 2010). From a measurement perspective, Rose and Rimes' (2018) review of self-criticism outcome measures identified self-criticism has been conceptualised in different ways, such as: occurring in response to difficult situations; a mood regulation strategy; a trait; or a repetitive process.

Theoretically, the development of self-criticism is suggested to be linked to difficult or traumatic childhood experiences (Brewin et al., 1992) which impact upon one's attachment relationship styles to oneself and others (Cantazaro et al., 2010). More recently, minority stress models recognise that for minority groups, such as sexual minorities, the stress of receiving stigmatising societal messages and prejudice influences self-criticism development (Heiman, 2017; Meyer & Frost, 2013).

Various psychological therapy approaches use overarching theories, such as attachment theory to conceptualise self-criticism in different ways (Bergner, 2013; Chang, 2008; Schanche, 2013; Shahar, 2015). Kannan and Levitt's (2013) review suggests that cognitive therapies conceptualise self-criticism at a thought or schema level, compared with emotion focused therapies, which conceptualise self-criticism as a fragmentation of one's self

and affective states. Several psychological therapies exist which target self-criticism explicitly, such as Beck's (1967) original conceptualisation of cognitive therapy for depression, compassion focused therapy (Gilbert, 2010) and emotion focused therapy (Brennan et al., 2014).

Due to the diversity of interpretations of self-criticism, this review has chosen a broad definition: "*A conscious evaluation of oneself that can be a healthy and reflexive behaviour, but also can have harmful effects and consequences for an individual"* (Kannan & Levitt, 2013, p. 1).

1.2. Impacts of self-criticism as highlighted in research

Problematic self-criticism has been associated with increased difficulties across a wide range of individuals grouped into psychiatric diagnostic categories, such as: depression (Cox et al., 2004a; Zhang et al., 2019); social anxiety (Shahar et al., 2015); psychosis (Waite et al., 2015); borderline personality disorder (Kopala-Sibley et al., 2012); body focused repetitive disorders (Houazene et al., 2021); and post-traumatic stress disorder (Cox et al., 2004b).

Related to physical health, self-criticism has been found to affect how people cope with receiving a cancer diagnosis (Austin et al., 2021), and predict psychological distress in people experiencing endometriosis (Geller et al., 2021). Self-criticism has also been associated with increased difficulties with hoarding behaviours (Chou et al., 2018), self-harm (Gilbert et al., 2010) and severity of eating difficulties (Zelkowitz et al., 2019).

Excessive self-criticism has been found across many different groups of people who may or may not experience significant psychological distress as a result, such as: students (McIntyre et al., 2018); therapy trainees (Kannan & Levitt, 2017); and people experiencing in-work poverty (Llosa et al., 2022). Self-criticism is found to be present, however may

function differently, depending on one's culture (Aruta et al., 2021; Chang, 2008; Feinson & Meir, 2014), sexuality and gender identity, (Puckett et al., 2015) and age (Kopala-Sibley et al., 2013).

Problematic self-criticism has been associated with worse intervention outcomes, where Löw et al.'s (2020) recent meta-analysis found an association between higher scores of problematic self-criticism and poorer therapy outcomes. Higher ratings of self-criticism have also been linked to greater difficulties in developing and maintaining a working therapeutic relationship in therapy, which is also understood to impact therapy outcomes (Whelton et al., 2007).

Developing knowledge about self-criticism in research and practice could therefore support the delivery of effective targeted support for people experiencing problematic self-criticism and potentially aid usage of limited healthcare resources more efficiently. However, despite the interest and increasing breadth of research on self-criticism, a large majority of studies have used quantitative research methods as briefly described above. Less qualitative research exists investigating individuals' experiences of self-criticism. The limited number of studies has also yet to be summarised in a review.

1.3. Qualitative self-criticism research

Qualitative research in this area has typically been gathered in the context of feasibility and acceptability of intervention (Rose et al., 2018), post-intervention feedback (McManus et al., 2018) or gaining clients feedback about the use of self-compassion intervention techniques to increase self-compassion and reduce self-criticism (Gilbert & Irons, 2004).

Other qualitative research focusing on self-criticism directly has focused on the content of individuals' self-critical statements. Bailey et al. (2022) used real commercially

available emotion focused therapy client sessions to investigate how self-criticism was articulated by clients. Using established coding systems, they identified different behavioural, cognitive and emotional aspects of self-criticism. The behavioural domain was found to be the most represented, where individuals' self-critics most frequently pointed out individuals' "*wrong behaviours*" (p.5).

Another approach by Halamová et al. (2020) investigated individuals' free associations for the words: 'criticism' and 'self-criticism'. They also found that the behavioural aspects of self-criticism were most frequently reported, where individuals' expressed motivations to improve, expressions of attacking oneself and other behavioural expressions such as lecturing. The authors highlighted future research could benefit from investigating the meanings of self-criticism in order to better understand clients' experiences of self-criticism.

1.4. Review rationale and aims

Since self-criticism has been highlighted to have significant links with various psychological difficulties and has been linked with poorer intervention outcomes, increasing understanding in this area has direct implications for improving clinical practice.

This novel, exploratory review aimed to systematically identify research which explores the experiences of self-criticism from a qualitative approach and provide a synthesis of findings. Since self-criticism is understood to be a transdiagnostic factor in mental health, no particular restrictions were placed upon the review scope (e.g., not investigating experiences of self-criticism only in relation to depression or only in clinical samples). This sits within the wider review's aim to further develop the understanding of self-criticism for practitioners and researchers that prioritises and values individuals' voices and experiences,

in line with NHS values (Department of Health and Social Care, 2021). This review aims to investigate the question “what are individual’s experiences of self-criticism?”.

2. Methods

2.1.Thematic synthesis overview

Thematic synthesis (Thomas & Harden, 2008) is a type of meta-synthesis which provides a procedure for analysing multiple qualitative studies to answer a specific research question. This allows the generation of new insights and concepts. The stages of thematic synthesis are described below (Table 1).

Table 1.

Thematic synthesis stages

Thematic synthesis stage	Description
Stage 1.	Searching for relevant studies
Stage 2.	Quality assessment of studies
Stage 3.	Data extraction and thematic synthesis: • Line by line coding to capture the meaning and content of text • Using codes to develop descriptive themes • Generation of analytic themes which consider new concepts and understanding

Stage one was completed by conducting a systematic literature search (2.2). Stage two was completed using quality assessment criteria (2.3). Stage three was then completed and described in more detail in 2.4.

2.2. Stage one: Search strategy

A systematic literature search of six online databases (ASSIA, EBSCO, Medline, PsychInfo, PubMed and Web of Science) was conducted in November 2022 using the

following search terms and Boolean operators: (“Self-critic*” OR “self critic*” OR “inner critic*” OR “inner-critic*” OR “self-attack*” OR “self attack”) AND (Qualitative* OR interview* OR “focus group*” OR “subjective experience*” OR experience* OR narrative* OR stories OR story OR phenomenol* OR meaning OR “grounded theory” OR thematic OR theme*). This identified 3988 references. Figure 1 summarises the screening and selection process using a modified PRISMA diagram (Page et al., 2021) using inclusion and exclusion criteria (Table 2). Eight studies were identified as meeting the criteria and their reference lists were hand-searched, however no new studies were identified.

Table 2.

Review inclusion and exclusion criteria

Inclusion	Exclusion
• Qualitative methodology used • Explores experiences of self-criticism predominantly • Significant exploration of experiences of self-criticism • Peer reviewed studies • Written in English language	• Quantitative methodology used only • Explores other aspects of self-criticism e.g. rating self-critical content in therapy sessions • Uses qualitative methodology predominantly to gather information about intervention acceptability, feasibility or feedback • Studies not specific to self-criticism (e.g. sole or predominant focus on self-compassion or self-esteem), without a significant focus on self-criticism • Grey literature

Initially this review identified six studies which solely focused upon individuals’ experiences of self-criticism outside of a therapy context. However, the search strategy above identified several studies which provided qualitative data about individuals’ experiences of self-criticism through using specific therapy techniques for self-criticism itself. These studies were found to provide insight into individuals’ experiences of self-criticism which could possibly only have occurred through use of the therapy technique itself. Widening this criterion

to include studies exploring people's experiences of self-criticism in the therapy context led to the inclusion of two additional studies (Bell et al., 2021; Brennan et al., 2014). This is in line with Thomas and Harden's (2008) thematic synthesis guidelines recommending inclusion of studies with the ability to provide relevant information to answer the research question to attain conceptual saturation. Eight studies were selected for this review and their summaries prior to meta-synthesis are summarised in Table 3.

2.3. Stage two: Quality assessment

The Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist was used to assess study quality. National Institute of Health and Care Excellence (NICE, 2012) guidelines and recent reviews recommend the CASP for quality monitoring in qualitative research (Ma et al., 2020; Long et al., 2020). A summary table of studies' critiques alongside CASP criteria is provided in Appendix A. Key identified methodological considerations of reviewed studies will now be explored in line with CASP criteria.

2.3.1. Aims and design

All studies clearly defined their aim(s) and qualitative research was considered appropriate and justified. All studies specified qualitative methodology used. Six studies used established procedures: three used interpretative phenomenological analysis (Bayir & Lomas, 2016; Bell et al., 2021; Waite et al., 2015); two used thematic analysis (Austin et al., 2021; Brennan et al., 2014); and one used framework analysis (Thew et al, 2017). Frentz et al. (2020) used interpretative description, a relatively new qualitative methodology considered appropriate to study individuals' experiences, however, less is known about the methods' strengths and limitations (Hunt, 2009).

Figure 1.

Modified PRISMA diagram

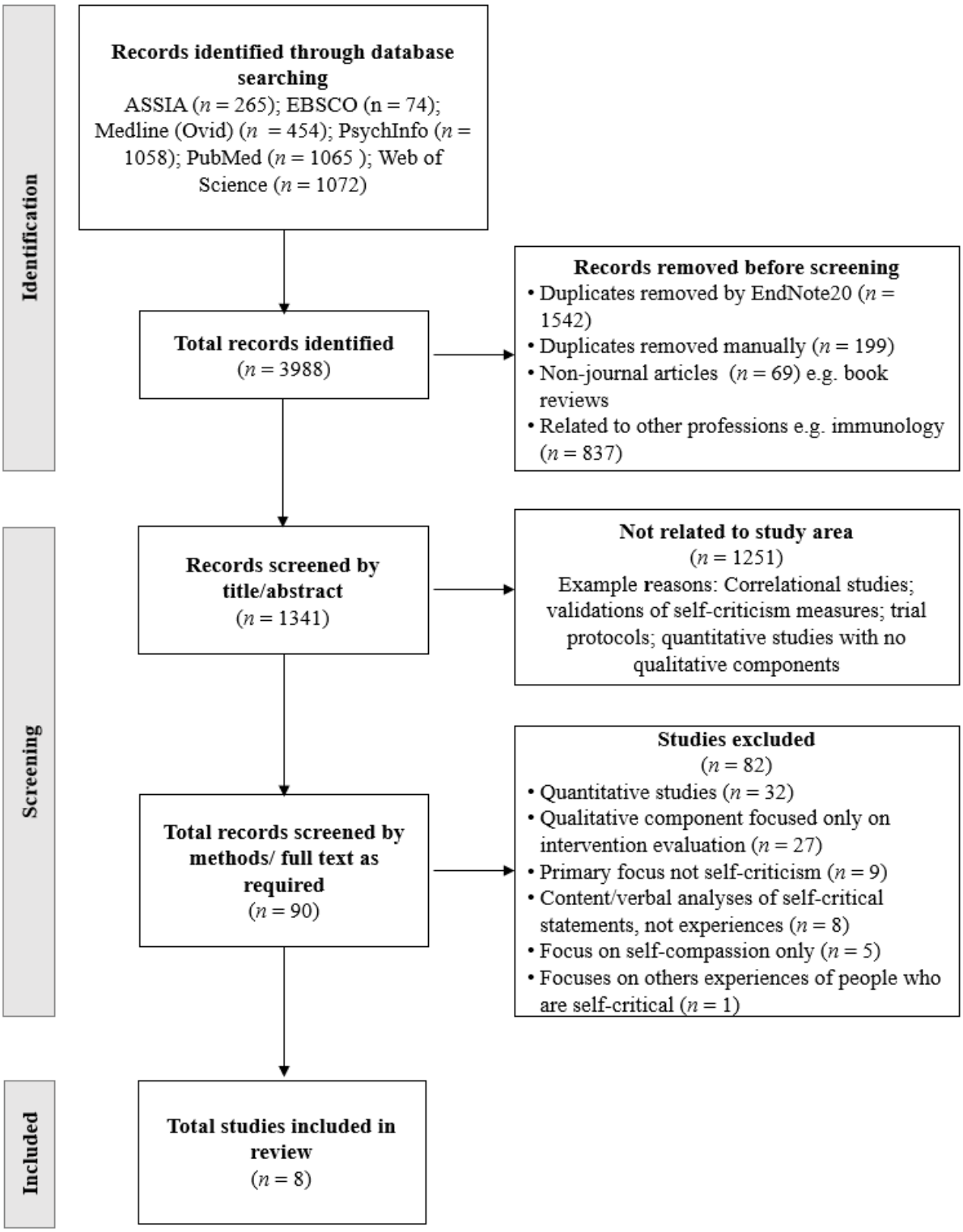

Table 3.

Summary of eight reviewed studies

Author(s), year, study title, (Country)	Relevant study aims	Sample characteristics	Design and analysis	Main relevant qualitative findings as reported
Austin et al. (2021). *Experiences of self-criticism and self-compassion in people diagnosed with cancer: A multimethod qualitative study.* (Netherlands)	To explore the ways people with cancer experience self-criticism.	• **Sampling:** Convenience and snowball sampling via personal and social media networks and oncology nurses. • **Participants:** 26 people who had received a cancer diagnosis in the past ten years. Cancer diagnoses were received between 6 months and 10 years previously (Mean = 3 years). • **Sex &Age:** 16 female, 10 male. Ages ranged between 22-78 years (Mean = 48 years). • **Ethnicity:** Not reported. • **Socioeconomic status:** Reports 81% participants had a "theoretical education". No other demographics reported.	Participants completed self-criticism and self-compassion exercises for two weeks prior to familiarise themselves with the topics. Individual and group semi-structured interviews then conducted. Data analysed using thematic analysis.	Four themes of self-criticism identified: • Being harsh or strict with yourself (High standards and pressing on; Staying strong and suppressing emotions; Not accepting choices and mistakes; Minimizing your needs; Mistrusting your body) • Feeling guilty or angry (For not being there for others; For lashing out at others; For unhealthy behaviours) • Feeling useless or like a burden (For not being able to perform social roles) • Feeling ashamed/not showing weakness (For visible signs of illness; To avoid pity)
Bayir & Lomas (2016). *Difficulties generating self-compassion: An interpretative phenomenological analysis.* (Turkey)	To explore individuals' experiences of barriers to self-compassion.	• **Sampling:** Snowballing starting with researchers' friends and acquaintances. • **Participants:** 4 people who identified as highly self-critical and low in self-compassion. • **Sex &Age:** 2 female, 2 male. Ages ranged from 25-31 years (Mean = 27.5 years). • **Ethnicity:** Turkish (n = 4). • **Socioeconomic status:** Undergraduate degree (n = 3), postgraduate degree (n = 1). No other demographics reported.	Semi-structured interviews. Data analysed using Interpretative Phenomenological Analysis.	Four themes identified: • Double edged sword: Perfectionism (Sense of inadequacy; The fear of failure) • The flaws of self-compassion (Self-compassionate people are "devil-may-care"; Self-compassionate people are "naughty and selfish") • The effects of a third person (Parental effect; Destructive comments at the workplace) • The advantages of self-criticism (Self-criticism as a shield; Self-criticism as a key of success)

Bell et al. (2021). *"Suddenly you are King Solomon": Multiplicity, transformation and integration in compassion focused therapy chairwork.* (UK)	To learn from client experience about shifting social mentalities when working with self-multiplicity in relation to self-compassion.	• **Sampling:** Identified by therapist in IAPT mental health service. • **Participants:** 12 participants experiencing depression who were receiving routine compassion focussed therapy (CFT) intervention in IAPT for self-criticism. • **Sex & Age:** 9 female, 3 male. Ages ranged between 19 and 53 years (Mean = 35 years). • **Ethnicity:** Asian-British (*n* = 1), Chinese (*n* = 1), White British (*n* = 8), White-Bulgarian (*n* = 1), White Irish (*n* = 1). • **Socioeconomic status:** None reported.	Following one single CFT chair work session, a face to face semi structured interview with questions about self-criticism was undertaken. Data analysed using Interpretative Phenomenological Analysis.	Three interconnecting themes identified: • Differentiating selves (Single to multiple; New selves, new potential) • Mental imagery of selves (Seeing selves; Past selves - memories and imagery) • Integrating and transforming selves with compassion (From conflict to integration; Transforming the critic: Fears and function)
Brennan et al. (2014). *Emotion-focused group therapy: Addressing self-criticism in the treatment of eating disorders.* (Alberta, Canada)	Explore participant perspectives on the process and outcomes of participating in an emotion-focused therapy (EFT) group for eating disorders with a focus on self-criticism	• **Sampling:** Recruited through University and community agencies. • **Participants:** 6 individuals with a formal eating disorder diagnosis who attended a weekly 12 session emotion focussed therapy (EFT) group. • **Sex &Age:** All female. Age range 22 to 58 years (No mean age reported). • **Ethnicity:** All participant ethnicity data reported as "Caucasian". • **Socioeconomic status:** All had an educational level of undergraduate degree or above. No other demographics reported.	Information gathered from post-intervention feedback forms and letters written by clients to their self-critical voices at the end of treatment. Data analysed using thematic analysis.	Six themes identified: • Struggling to separate from the critic • Recognising the destructive impact of the critic • Recognising the critic's protective function • Accessing and accepting previously avoided feelings • Accepting my needs • Valuing the group

Frentz et al. (2020). *Athletes' experiences of shifting from self-critical to self-compassionate approaches within high-performance sport.* (Canada)	Explore how athletes shifted from a self-critical to self-compassionate approach when managing sporting challenges.	• **Sampling:** Convenience sampling at a university campus and notices from sporting staff. • **Participants:**11 athletes self-identifying as excessively self-critical. • **Sex &Age:** 6 male, 5 female. Age range 19 to 35 years (Mean = 24.7 years). • **Ethnicity:** No ethnicity breakdown available, states participants were "predominantly caucasian Canadian". • **Socioeconomic status:** Not reported.	Semi structured interviews conducted with participants. Data analysed using interpretative description.	Five themes identified: • The role of the coach: Giving athletes the best opportunity to deal with setbacks • The influence of other athletes: "encouraging" but also "your competition" • The impact of important others: Defend or derail • Developing balanced self-awareness: "A clearer mind is the essence of sport and performance" • Maintaining an accepting mind-set: Acquire and assert your "mental toolbox".
Kannan & Levitt. (2017). *Self-criticism in therapist training: A grounded theory analysis.* (US)	To understand the experience of self-criticism in training therapists.	• **Sampling:** Purposive sampling to all students enrolled on clinical and counselling doctorate programmes at the University. Invitation also sent to other programme supervisors for snowballing. • **Participants:** 14 graduate trainees in clinical and counselling psychology doctoral programs. • **Sex &Age:** 11 females, 3 men. Ages ranges between 24 and 48 years (Mean = 29.6 years). • **Ethnicity:** Not fully reported. Reports *n* = 13 participants were caucasian. • **Socioeconomic status:** All in postgraduate training. No other demographics reported.	Semi structured interviews conducted. Data analysed using grounded theory.	Five overarching clusters were identified: • Self-criticism is tied to misconceived responsibility • Self-criticism functions as an interpersonal barometer • Supervisors' judgements increase shame and self-protection • Self-criticism reduces with experience and clinical exploration • Supervision can foster learning from self-criticism

Thew et al. (2017). *The phenomenology of self-critical thinking in people with depression, eating disorders, and in healthy individuals.* (UK)	To explore the experience of self-critical thinking	• **Sampling:** Clinical **s**ample identified by clinicians in local mental health service. Non-clinical sample recruited through university and community adverts. • **Participants:** 78 participants, 26 with a diagnosis of major depressive disorder; 26 with a current eating disorder diagnosis; 26 with no current or historical mental health problems. • **Sex &Age:** Not reported, though all participants stated as over 18. • **Ethnicity:** Not reported. • **Socioeconomic status:** Not reported.	Semi-structured interview exploring people's experiences of self-critical thinking. Data analysed using framework analysis.	Themes identified: • Presence, frequency and duration • Triggers • Control and management • Effects and impact • Onset and development • Making changes
Waite et al. (2015). *Self-compassion and self-criticism in recovery in psychosis: An interpretative phenomenological analysis study.* (UK)	Exploring how one relates to oneself and how this impacts recovery in psychosis with particular consideration to self-criticism.	• **Sampling:** Clinicians from mental health team identified potential participants who had experiences of psychosis. • **Participants:** 10 people with experiences of psychosis. Age of psychosis onset ranged from 16 to 43 years (Mean = 22.8 years). • **Sex & Age:** 3 female, 7 male. Ages ranged between 25 and 52 years (Mean = 38.5 years). • **Ethnicity:** English (*n* = 1), Mixed-British (*n* = 1), Mixed Caribbean (*n* = 1), Kashmiri (*n* = 1), Pakistani (*n* = 1), Pakistani-British (*n* = 1), White-American (*n* = 1), White- British (*n* = 3). • **Socioeconomic status:** Occupation status reported 7 people were unemployed, 3 people as doing voluntary work.	Semi-structured interview. Data analysed using Interpretative Phenomenological Analysis.	Five themes identified: • "My mind can't take the load": the "curse" of psychosis • The "trap" of self-criticism • "Coming to terms" with psychosis in my life to "move on" • "On my own two feet" • "An opportunity" for growth.

Seven studies used semi-structured interviews. One study (Brennan et al., 2014) did not use interviews and analysed participant's therapeutic letters to their self-critic, and intervention feedback following twelve EFT sessions. It was unclear why interviews were not also conducted, which possibly could have allowed the researcher to expand on participants' comments to add richness to the data.

Bell et al. (2021) and Brennan et al.'s (2014) studies were conducted in the context of therapeutic work specifically targeted towards participants' self-criticism. Austin et al. (2021) reported participants' awareness about the subject matter might be limited and asked people to familiarise themselves with content prior to interview. Thew et al. (2017) conducted interviews following a battery of questionnaires measuring self-criticism, perfectionism, depression, eating disorders, self-esteem, rumination, self-compassion, and functioning. They also reported participants were also undergoing an intervention, but it was unclear at what stage interviews were conducted. This could have primed interviewees towards these conceptualisations of self-criticism, potentially influencing subsequent content.

2.3.2. Sampling

Most studies provided adequate descriptions of sampling procedures, which were appropriate to their study aims. Bayir and Lomas (2016) did not explain the choice to recruit via their friends and acquaintances, rather than other methods such as social media. Three studies (Bell et al., 2021; Thew et al., 2017; Waite et al., 2018) asked clinicians in mental health services to identify potential participants. Whilst potentially common practice, this could raise ethical concerns around gatekeeping and how clinicians determine eligibility (or ineligibility) for research (Sharkey et al., 2010).

A major concern was identified regarding incomplete demographics reporting. Complete ethnicity data was not reported by four studies (Austin et al., 2021; Frentz et al.,

2020; Kannan & Levitt, 207; Thew et al., 2017). Of major concern was that only the ethnicity of white or caucasian individuals was reported in two studies (Frentz et al., 2020; Kannan & Levitt, 2017), with the ethnicity of remaining individuals not reported. Academia, medical and clinical psychology professions have been criticised for colonialist and institutionally racist practices (Cullen et al., 2020; Fernando, 2017). It is possible these omissions are linked to such wider systemic issues, which could raise ethical concerns about how these participants were respected and their research contributions valued, and likely limitations to the cultural relevance of findings.

No studies reported other participant demographics, such as faith, sexuality or socioeconomic status, however four studies did report some participants levels of educational attainment (Austin et al., 2021; Bayir & Lomas, 2016; Bell et al., 2021; Kannan & Levitt, 2017) and participants' employment status (Waite et al., 2015). Across three studies, all participants attained undergraduate degrees or higher (Bayir & Lomas, 2016; Brennan et al., 2014; Kannan & Levitt, 2017), however it should be noted that Kannan and Levitt's (2017) study was purposefully investigating the experience of self-criticism in doctoral therapy trainees. Additionally, the meaning of participants holding a "theoretical education" was not clear in one study (Austin et al.'s, 2021, p.5). Thew et al. (2017) did not report participants' age and gender. Only Bayir and Lomas's (2016) study was not conducted in a Western culture.

The over-representation of academically educated participants is in line with a major criticism in research, finding samples are often comprised of Western, Educated, Industrialised, Rich and Democratic (WEIRD) characteristics (Henrich et al., 2010). Additionally, socioeconomic status is considered an important determinant of health (Kivimäki et al., 2020), likely impacting one's thoughts, feelings, behaviours and identity (Manstead, 2018). This could therefore have a direct implication on these studies findings in

relation to self-criticism. Without adequately reporting and considering the impact of individuals' demographics, structural biases against underrepresented, disadvantaged and minoritized groups of individuals may be maintained, and implications for the external validity and relevance of findings may be limited.

2.3.3. Reflexivity and rigour

Reflexivity is an integral component of qualitative research, allowing researchers to identify, examine and monitor their own biases and assumptions which could influence the validity of findings (Jootun et al., 2009). Three studies did not report any reflexive analysis (Austin et al., 2021; Brennan et al., 2014; Thew et al., 2017). The remaining five studies reported reflexivity methods in varying detail. Frentz et al. (2020) reported considerable detail regarding the lead researchers' identification with participants and methods to mitigate biases, such as a reflexive diary, and methods to remain close to data. Kannan and Levitt (2017) explicitly stated their prior assumptions, providing personal information about the researchers' demographics in addition to keeping notes about biases throughout. Remaining studies attended to reflexivity in varying details, using bracketing interviews, journals and discussions throughout their studies.

Seven studies described the process of data analysis according to the qualitative method chosen in varying levels of detail considered acceptable. However, Brennan et al. (2014) only described the general process of thematic analysis, not how this was applied within their study.

Reliability and consistency of findings checks were undertaken by use of two or more researchers either evaluating the whole or sections of dataset in six studies (Austin et al., 2021; Bell et al., 2021; Frentz et al., 2020; Kannan & Levitt, 2017; Thew et al., 2017; Waite et al., 2015). Three reported using independent coders outside of their research team (Bell et

al., 2021; Thew et al., 2017; Waite et al., 2015). Only one study reported inter-rater reliability statistics for categories (Thew et al., 2017). In two studies, the number of data analysts was unclear where it appears one researcher analysed data alone (Bayir & Lomas, 2016; Brennan et al., 2014). Respondent validation was undertaken in two studies (Frentz et al., 2020; Kannan & Levitt, 2017).

2.3.4. Ethical considerations

Protecting participants from harm and valuing their safety is a key concern in clinical practice (Health & Care Professions Council (HCPC), 2015) and research (British Psychological Society (BPS), 2021a) and are key to safe, respectful and ethical working.

Five studies clearly reported receipt of ethical approval from a University, NHS or Health research committee, where three studies did not report ethics approval despite these studies appearing connected to universities (Bayir & Lomas, 2016; Frentz et al., 2020; Kannan & Levitt, 2017). It is possible that ethics processes were followed, however not reported. For the four studies involving participants with experience of psychological difficulties recruited from healthcare settings, three appropriately considered the risk, safety and capacity to consent for these participants (Brennan et al, 2014; Thew et al., 2017; Waite et al., 2015). One study (Bell et al., 2021) did not report how this was managed, however the study was conducted in a primary care mental health service which do not typically hold risk. None of the eight studies reported procedures devised to support individuals should clinical concerns arise. However, the participants undertaking therapy were receiving support throughout the study and these procedures may have been discussed elsewhere, for example, in service meetings, information and debrief sheets.

2.3.5. Presentation of findings

Overall, the majority of studies presented findings clearly, often including participant quotes within category headings and demonstrating category content. Waite et al.'s (2018) study could have benefitted from a clearer structure since new information and a thematic diagram was introduced in the discussion. Thew et al.'s (2017) findings could have benefitted from clearer overall summary of categories and clear demarcation of major and subcategories in text and in the discussion.

2.3.6. Summary of critical appraisal of studies

The evaluation of studies using the CASP framework (Appendix A) did not identify any studies requiring exclusion for very poor quality. All eight studies were considered adequate for this review and synthesis in accordance with Thomas and Harden's (2008) guidelines.

2.4. Stage three: Thematic synthesis method

Several studies contained aims and content considered outside the review scope. This review only extracted data relating to self-criticism for coding. Other information or constructs, for example, experiences of self-compassion only were not coded. Participants' experiences of therapeutic techniques and the process of change in self-criticism were not coded since these were also considered to be different areas of investigation. However, any insights, reflections gained about participants' experiences of self-criticism that occurred as a result of the intervention increasing awareness about the nature of their experiences of self-criticism were coded. Participant quotes and study authors' summations and reflections of participants experiences were coded together.

In accordance with procedure in Table 1, line-by-line coding was completed to facilitate the process of remaining as close to the data as possible. Codes were then grouped into descriptive themes from which analytic themes were developed.

The study author had already completed previous research investigating how clinical psychologists understand and work with self-criticism. To manage the potential impact that prior experience in this field might have had upon the reliability and validity of findings, two independent reviewers experienced in qualitative research methods were briefed on the study's aims and Thomas and Harden's (2008) thematic synthesis method. Each were given a random sample of initial line by line codes to check closeness to the data and accuracy of coding. Reviewers were then given lists of descriptive and analytic themes which were linked back to the line-by-line codes to check consistency and agreement. Discrepancies and suggestions were discussed, and adaptations were made. The final draft results were then taken back to a member of the study's research team who had experience in the area of self-criticism research and small minor amendments were made, for example to the wording of themes. Examples are provided in Appendix B-C.

3. Thematic synthesis results

Four central themes were inductively developed from the analysis to capture individuals' experiences of self-criticism, along with twelve sub-themes (Table 4).

Each central theme appeared to reside on a spectrum representing the dynamic aspect of how individuals experienced self-criticism. Some participants undergoing therapy experienced aspects of their self-criticism as having real impacts on them, while remaining outside their awareness. As their therapy progressed, their awareness of unknown aspects of their experience of self-criticism changed to known aspects.

Table 4.

Overview of central and subthemes.

Central theme	Subthemes
Origins and triggers of self-criticism: past and present	• Childhood experiences • Hypercritical environments • Health • Standards, expectations and sense of responsibility • Specific triggers
Qualities of self-criticism as harsh and distorting	• Constant harsh attacks • Automatic versus deliberate self-criticism • Distorting reality
Known and unknown impacts of self-criticism	• Known negative impacts of self-criticism • Becoming aware of previously unknown impacts of self-criticism • Strategies to manage self-criticism
Self-criticism as a survival mechanism, achievement motivator or moralising force	• Protects me, keeps me safe and motivates me • Misconceptions about self-compassion and fear of being without self-criticism

3.1. Origins and triggers of self-criticism: past and present

3.1.1. Childhood experiences

This theme encapsulates the finding that some participants with or without mental health difficulties linked their experiences of self-criticism to their childhood experiences, particularly of parental relationships: *"My father was extremely critical, I was very criticised, so the seeds were there from childhood"* (Thew et al., 2017, p.17). This also included parents': high standards and expectations (see also 3.1.4); intolerance of making mistakes; anxiety driven overplanning; comparisons to siblings; and unsupportive comments (Bayir & Lomas, 2016; Bell et al., 2021; Thew et al., 2017).

Other participants with experiences of depression and eating difficulties specified their self-criticism was linked to childhood memories of being criticised, feeling shame and humiliation, or experiencing trauma from parents, relatives or teachers (Thew et al., 2017).

The link between the origins and current experiences of self-criticism were not always known for participants until receiving an intervention. For example, Bell et al. (2021, p.230) noted "*For some participants the links between historic events and current self-criticism were novel and surprising".* After experiencing an EFT group intervention, one participant who struggled to manage their difficulties with eating, reflected on realising the origins of their self-criticism as "*Not something I have internally generated, but rather are an amalgamation of external discourses from influential individuals in my life and from popular culture I have internalised"* (Brennan et al., 2014, p.70). This person was able to recognise how many different experiences had contributed to their difficulties, including childhood experiences. This indicates that the awareness for some individuals of their experience of the origins of their self-criticism differs, and how individuals experiencing an intervention appeared to uncover origins of their self-criticism.

3.1.2. Hypercritical environments

For participants without experiences of mental health difficulties only, the origins of their current experience of self-criticism were clearly identified and known, often linked to a critical or unsupportive other person in a particular past or current setting. For therapists this was their supervisor (Kannan & Levitt, 2017), for athletes this was their coach (Frentz et al., 2020) and for individuals sampled from the general population, this was their work manager (Bayir & Lomas, 2016).

Self-criticism was linked to critical work managers': hostile comments, magnifying any tiny mistakes to others and infrequently providing positive feedback (Bayir & Lomas,

2016). Several athlete participants experienced a "*Downhill spiral of becoming self-critical*" (p.573) following excessive and abusive criticism from their coaches, who some people experienced as treating them like a "*Commodity*" (p.573), focused on performance, not treating them as a person (Frentz et al., 2020). However, participants also appreciated constructive criticism from coaches they had a supportive relationship with who held high performance standards but were clear about their expectations and ways to develop their sporting performance (Frentz et al., 2020). For trainee therapist participants, self-criticism was linked with their experience of supervisors, where having a supervisor who only focused on negatives increased their self-criticism (Kannan & Levitt, 2017). Notably these three studies all contained non-clinical populations where hypercritical environments were clearly linked to increased and excessive self-criticism.

3.1.3. Health

Another clearly known origin of self-criticism for some individuals was linked to a change in their health. For some people their experience of self-criticism changed following a diagnosis of cancer, particularly when they lost their hair or perceived themselves as unable to fulfil social roles or "*Not contributing to society*" (Austin et al., 2021, p.5). Self-criticism was also identified as a potential trigger towards the onset and relapse of individuals' psychosis, which could be triggered by blame, internal or external stigma, "*It's all my fault"* (Waite et al., 2015, p.1208). Self-criticism itself was also linked to the development of psychosis *"I used to be critical of myself….harsh on myself, which I suppose I feel pressurised and became ill"* (Waite et al., 2015, p.1208).

3.1.4. Standards, expectations and sense of responsibility

Participants with or without experiences of mental health problems clearly linked their self-criticism to known high unachievable standards, excessive levels of responsibility

and control of issues, and comparing themselves to others (Austin et al., 2021; Bayir & Lomas, 2016; Kannan & Levitt, 2017). Commonly standards revolved around performance, such as at work "*There is a gap between where I'd like to be and where I'm at"* (Kannan & Levitt, 2017, p.7) or in sporting performance "*I just kept tearing myself down because I wanted to be the best of the best"* (Frentz et al., 2020, p.576). However, for individuals who had received a diagnosis of cancer, their standards were focused on other aspects, such as their health: "*Eating something unhealthy just for once would be okay, but I don't allow it at all"* (Austin et al., 2021, p5) and their reduced ability to complete their usual daily activities prior to diagnosis.

For some individuals, it was considered acceptable for others to make mistakes, but standards were different for oneself compared with others: "*For yourself you're just much harsher, that's the difference"* (Austin et al., 2021, p.5). These standards link to section 3.4., whereby Bell et al.'s (2021) study involving individuals with experiences of depression undertaking a CFT intervention, recognised "*Half of all participants also identified the use of the critic to motivate and maintain personal and performance standards"* (p.231). However, the extent to which this population was aware of such a link prior to the intervention was not clear.

3.1.5. Specific triggers

Linking to the above areas, Thew et al. (2017) reported a variety of internal and external triggers of self-criticism in people without mental health difficulties, and people with experiences of depression or eating difficulties. They reported that the majority of participants without mental health difficulties (95%), experienced their triggers of self-criticism as external, compared with 61% of the depression group. For the people experiencing eating difficulties, 61% reported their triggers for self-criticism as internal.

Thew et al. (2017) reported a number of similar triggers across all groups such as "*Thinking about particular topics (past mistakes/failures, relationships with others, or the future); anxiety or worry; tiredness; or feeling a lack of achievement/productivity"* (p.13). Some triggers differed per group and were related to their specific difficulties. For example, mealtimes, appearance and mirror were identified as triggers for individuals with eating difficulties. Social media was a particular trigger identified by one participant with eating difficulties "*"If I'm just on social networking sites like Facebook and pictures pop up of people, then I'm instinctively quite [self] critical"* (Thew et al., 2017, p.12). For one participant with a diagnosis of psychosis, self-criticism itself was a "*Blazing red sign"* to them which could trigger relapse (Waite et al., 2015, p.1207). The extent to which such triggers were known and unknown prior to intervention was not clear.

3.2. Qualities of self-criticism as harsh and distorting

3.2.1. Constant harsh attacks

The majority of studies focused on people with and without experiences of mental health difficulties identified self-criticism as having particular qualities, where it does *"Not just speak, but nag, yell, sneer and denounce*" and can be experienced as "*Laughing at me*" (Brennan et al., 2014, p.71), having harsh, strict and vicious qualities (Austin et al., 2021; Bayir & Lomas, 2016; Bell et al., 2021; Brennan et al., 2014). Some people experienced self-criticism as an attack, fight or battle which "*Besieges your brain*" (Bell et al., 2021, p.22).

Self-criticism was experienced as automatic and *"Habitual"* (Brennan et al., 2014, p.17; Thew et al., 2017), which can "*Snowball*" (Thew et al., 2017, p.18). This could keep people experiencing a "*Constant endless litany of abuse"* (Brennan et al., 2014, p.68), where participants become stuck in cycles where distress is maintained. One participant identified a vicious cycle where self-criticism can trigger their psychosis and their psychosis triggers self-

criticism (Waite et al., 2015). Another participant identified a cycle of "C*riticizing myself for being critical"* (Kannan & Levitt, 2016, p.9).

3.2.2. Automatic versus deliberate self-criticism

Within and between studies, there were differing perspectives regarding whether a person felt in control of their self-critical experiences, which was affected by the origins and triggers of self-criticism (3.1.). Participants with experiences of mental health difficulties recognised that at times they experienced "*Little control over their self-critical thoughts*" where self-criticism is "*Like a constant hum in the background and occasionally the noise gets turned up*", rendering change immensely difficult (Thew et al., 2017, p.13 & p.11). At other times, individuals experienced deliberately criticising themselves following mistakes whether they were in clinical or non-clinical populations (Thew et al., 2017). However, the deliberate nature of self-critical thoughts for people without mental health problems could serve a different function, "*Occasionally I will [bring on self—critical thoughts] at work to analyse how I could do something better…or work with somebody better"* (Thew et al., 2017, p.13).

3.2.3. Distorting reality

Participants who had undertaken EFT to manage their self-critical thoughts noticed a realisation that they hadn't previously noticed their self-criticism had "*Lied to me*", been "*Deceiving me*" and was "*Distorting my view of what life is and can be"* (Brennan et al., 2014, p.71). Bayir & Lomas (2016) identified the trap of perfectionism which *"Lures participants in with the prospect of making fewer mistakes and having more success"* (p.25) which in turn led participants to "*Downplay the downsides of perfectionism"* (p.22).

Two studies provided participants with exercises to consider multiple aspects of oneself, noticing that participants experienced the self-critical aspect of themselves as a

"*Singular, stable and fixed*" (Bell et al., 2021, p.228) part of themselves from which they were unaware they could separate prior to intervention (Brennan et al., 2014). Self-criticism was experienced by participants as "*Who I am*" (Thew et al., 2017, p.18) and as "*'Hard fact' or 'reality' rather than just one possible version of things*" (Brennan et al., 2014, p.71). Consequently, participants often only identified with the critical parts of themselves and did not always experience a realisation that they were able to disagree with their self-criticism (Bell et al., 2021; Brennan et al., 2014; Kannan & Levitt, 2017; Thew et al., 2017). This particular subtheme captures the finding where participants' increased awareness appeared to change their experience of self-criticism to see it as one distorted perspective.

3.3. Known and unknown impacts of self-criticism

All studies identified impacts and consequences of self-criticism, which varied considerably between participants in terms of how they were experienced as known or unknown.

3.3.1. Known negative impacts of self-criticism

Participants with and without mental health difficulties identified some clear known physical and emotional impacts of self-criticism, finding they were *"Exhausted*" (Bayir & Lomas, 2016, p.26) and that "*It makes life very hard, it's very tiring having that going on in your head […] it just takes all the sparkle out of things*" (Thew et al., 2017, p.16), leading to them feeling "*Useless and have no hope*" (Brennan et al., 2014, p.71). Participants in five studies (Austin et al., 2021; Bayir & Lomas, 2016; Brennan et al., 2014; Frentz et al., 2020; Kannan & Levitt, 2017) identified participants frequently experienced feelings of inadequacy and uselessness in response to their self-criticism.

Participants identified that self-criticism *"Limits what you believe you can do*" (Thew et al., 2017, p.16), impacting mood and activity levels (Waite et al., 2015), rendering it "*Hard*

to function" (Brennan et al., 2014, p.71) placing considerable pressure on people to perform without making any errors (Bayir & Lomas, 2016). Participants appeared to find it easier to identify impacts of self-criticism on their concentration, ability to manage their cancer, isolation and ability to ask for help, general low mood, shame and guilt, anxiety and fear, productivity, minimising their needs, and on their safety (Austin et al., 2021; Brennan et al., 2014; Kannan & Levitt, 2016; Thew et al., 2017; Waite et al., 2015).

Participants in Bayir and Lomas' (2016) study particularly noticed that their self-criticism meant that when they did achieve their goals, they felt "*Stupid*" (p.22), as if "*Something is missing*" (p.22), it was "*Not the end*" (p.21), they were "*Not even able to recognise my accomplishments*" (p.26), never feeling satisfied or getting pleasure from tasks or achievements.

3.3.2. Becoming aware of previously unknown impacts of self-criticism

This category describes the finding that participants may experience impacts of self-criticism that may be at times outside of their awareness and initially be unknown.

In two studies where participants with mental health difficulties received CFT and EFT interventions, they began to uncover aspects of their experience of self-criticism that were previously hidden or obscured. Through undergoing EFT, one participant was able to identify their self-criticism had deprived them "*Of my ability and will to acknowledge and validate my worth*" (Brennan et al., 2014, p.71). Another participant commented that "*You do not realize how sad you are when you are listening to that self-critic*" (Bell et al., 2021, p.230) where the study authors commented that participants were "*Shocked at the intensity of internal conflict*" (p.231) when their self-criticism was experienced through externalisation.

Different aspects of one's self-criticism may be hidden or visible for different people, where in Frentz et al. (2020), one participant without mental health difficulties stated that

they "*Didn't even realise I was saying those things to myself*" (p.575). Participants in Bell et al. (2021) realised their experiences of self-criticism were akin to being "*Bullied*" (p.231) and being in an "*Abusive relationship*" (p.231) where the part of themselves receiving the criticism was previously obscured and not experienced.

Brennan et al. (2014) identified that participants did not realise they had "*Internal needs that had been avoided or unmet*" (p.72). Bayir and Lomas' (2016) non-clinical study summed up their perception of participants experiences, noting that self-criticism rendered people unable to consider that their mistakes were an *"Inevitable aspect of their common humanity*" (p.22), and which often had the hidden impact of "*Isolating them from humanity because of their mistakes*" (p.22) with no "*Space for their imperfections and personal flaws"* (p.21). A participant in Brennan et al.'s (2014) study realised their self-criticism had been "*Reducing me to an amalgam of deep and incurable flaws*" (p.71). Participants therefore did not "*Consider mistakes as part of the learning process"* (Bayir & Lomas, 2016, p.22) and self-kindness was eliminated.

3.3.3. Strategies to manage impacts

Five studies (Austin et al., 2021; Frentz et al., 2020; Kannan & Levitt, 2017; Thew et al., 2017; Waite et al., 2018) described participants' experiences of helpful and unhelpful strategies to manage the impacts of self-criticism, such as: distractions, keeping busy, suppressing emotions, social support, gaining other people's perspectives, and engaging in meaningful activity. These studies were conducted with people with and without mental health difficulties.

Frentz et al. (2020) and Kannan and Levitt (2017) in particular highlighted managing self-criticism became easier when they experienced supervisors and coaches support with viewing mistakes as a key part of the process of learning processes. Key recognitions were

identified such as "*One moment doesn't define you*" and "*Being accepting of yourself whether you perform well or not"* (Frentz et al., 2020, p.578). This made it possible to maintain high standards and performance in a healthy way. However, these two studies were conducted with people without experiences of mental health difficulties.

3.4. Self-criticism as a survival mechanism, achievement motivator or moralising force

3.4.1. Protects me, keeps me safe and motivates me

All studies except Austin et al. (2021), highlighted the important functions that self-criticism served for participants. Self-criticism was most frequently viewed as serving a protective function from: one's fear of failure; guarding against repeating mistakes or making future mistakes; limiting their exposure to perceived weakness, harm and vulnerability; and providing a sense of control (Bayir & Lomas, 2016; Bell et al., 2021; Brennan et al., 2014; Thew et al., 2017). Following therapy, one participant's letter to their self-critic recognised "*I've also come to realise that at other points in my life, you probably saved me […] allowed me to cope, albeit in a destructive way, with extremely difficult situations"* (Brennan et al., 2014, p.71).

Self-criticism was also viewed as serving some more positive perceived functions, such as motivating people to achieve, highlighting aspects of oneself to work on, increasing productivity and performance, self-improvement, and success (Bayir & Lomas, 2016; Brennan et al., 2014; Thew et al., 2017). This perception was more common for participants without mental health difficulties who experienced greater control over their self-criticism "*I think it's quite helpful for your inner voice to say […] 'that wasn't very nice what you just said to that person, no excuses, I don't care that you're upset or what have you, go back and say sorry'"* (Thew et al., 2017, p.16).

There was a complexity of the functions that self-criticism served, where one study's authors noted that some participants "*Value excellence despite of (sic) its self-destructive impacts*" (Bayir & Lomas, 2016, p.21). Self-criticism was reinforced when people received external validation from others about the good quality of their work (Bayir & Lomas, 2016; Thew et al., 2017).

3.4.2. Misconceptions about self-compassion and fear of being without self-criticism

This category captures the finding that a less obvious function of self-criticism was to protect oneself from the perceived dark sides of self-compassion and absence of self-criticism, "*When self-compassion enters your life, in my opinion, your arrogance will increase necessarily… Probably you will become more snooty and conceited… These personal traits may define your life"* (Bayir & Lomas, 2016, p.24).

Participants with and without mental health difficulties identified links between continued self-criticism and misconceptions about self-compassion, such as that self-compassionate people are careless, reckless, blame others for their mistakes, selfish, spoilt, oblivious and superficial (Bayir & Lomas, 2016). Participants also feared consequences of not being self-critical, such as laziness, untidiness and being unsuccessful (Bayir & Lomas, 2016; Thew et al., 2017).

4. Discussion

4.1. Summary of review findings

This study used thematic synthesis to generate an understanding of individuals' experiences of self-criticism. Four central themes were identified: origins and triggers of self-criticism past and present; qualities of self-criticism as harsh and distorting; known and unknown impacts of self-criticism; and self-criticism as a survival mechanism, achievement

motivator or moralising force. However, it was noticed that within each theme, individuals' experiences of self-criticism were dynamic and changed depending on whether they had developed an awareness about it through exploration. Some individuals uncovered previously unknown aspects of their experience of self-criticism during psychotherapy.

These findings fit with existing psychological theory which conceptualise self-criticism as being shaped by early life experiences and hypercritical environments (Beck, 1976; Blatt, 1974; Gilbert, 2010; Young, 2006). Research has also identified links between self-criticism and holding high standards for oneself (Thompson & Zuroff, 2004) which has also been associated with the development and maintenance of perfectionism (Kannan & Levitt, 2013).

The constant harsh, attacking qualities of self-criticism identified in this review have also been captured in previous research (Kannan & Levitt, 2013; Shahar, 2015) and in self-criticism psychometrics, such as in the 'forms of self-criticizing/attacking and self-reassuring scale' (Gilbert et al., 2004).

Self-criticism has also been recognised in research as serving different functions for individuals, including protection and motivation (Gilbert et al., 2004). This fits with the findings of this review, however it should be noted that these functions were most frequently identified by individuals undergoing CFT or EFT interventions. These models explicitly consider protection and motivation to be typical functions of self-criticism for individuals (Gilbert, 2010; Greenberg, 2011), therefore this finding could possibly reflect participants identification with the model's understanding.

The finding that individuals' self-criticism was related to misconceptions about self-compassion and self-criticism fits with previous research. Gilbert et al. (2011) found that for

self-critical individuals, their ability to be self-compassionate was affected by their fears of self-compassion.

4.2. Review strengths and limitations

A strength of this review was that it addressed a gap in the literature where individuals' experiences of self-criticism had not previously been synthesised. This review valued individuals' voices and experiences in the evidence base and it was hoped that study findings could inform tailoring future research and interventions to contribute to the delivery of effective, client centred care.

Due to the novel exploratory nature of the review and sparsity of previous research conducted, few limitations were set around the inclusion and exclusion criteria. This meant that studies involving clinical and non-clinical sample were selected, as well as studies considering self-criticism within a therapeutic context. Whilst clinical contexts may influence how people experience self-criticism and possibly reflect therapy models, the range of contexts can also be seen as a strength of this review in that it provides an overview of themes relevant to different individuals in clinical and non-clinical contexts. Themes may therefore be widely generalisable.

All studies considered self-criticism almost exclusively from a problematic perspective and therefore this review provides less insight into the experiences of constructive, healthy self-criticism. Little research exists in this area, where constructive adaptive self-criticism may also be conceptualised as self-enhancement (Kurman et al., 2003) or considered within the context of self-compassion (Neff, 2011). Self-compassion has been a recent focus of research and may be considered as the antidote or as an opposite to self-criticism (Gilbert & Procter, 2006; Greenberg, 2011). Qualitative research may therefore have explored self-criticism more indirectly, by exploring experiences of self-compassion or

difficulties with self-compassion (Gilbert et al., 2014; Klingle & Va Vliet, 2019). However, this may result in some conceptual confusion regarding how self-criticism and self-compassion are defined and understood. Future research could be conducted in this area to provide a broader overview of the experiences of self-criticism. Future research could consider developing an agreed definition of self-criticism, and further explicating its relationship with self-compassion. This could then provide a basis for research to consider how individuals might hold both constructive and destructive self-criticism or move from constructive to destructive self-criticism and vice versa.

One particular study limitation regards the nature of collating studies for synthesis. Several studies did not adequately report their data analysis and quality control procedures, which has implications for the validity of this review's findings. As such findings should be treated with caution. However, Thomas and Harden's (2008) thematic synthesis methodology was chosen to account for this, where they recommend studies are included based on their ability to answer the research question, rather than study quality, though findings should be presented in the context of a quality assessment.

Most reviewed studies took place in Western countries with educated white participants. The reporting of participant demographics, particularly ethnicity, sex, age and socioeconomic status was also incomplete in several studies. Demographics, such as faith, sexuality and gender identity were not reported in any studies. This limits the generalisability of findings across cultures, individual characteristics and socioeconomic factors. Existing evidence suggests that self-criticism may function in different adaptive and destructive ways depending on one's: culture (Aruta et al., 2021; Chang, 2008; Feinson & Meir, 2014), sexuality and gender identity (Puckett et al., 2015), age (Kopala-Sibley et al., 2013) and experiences of poverty (Llosa et al., 2022). Future research would benefit from investigating

the experiences of self-criticism from individuals from a variety of backgrounds to capture a rich and representative understanding of self-criticism.

4.3. Research implications

This review found that some aspects of individuals' experiences of self-criticism may be unknown to them, and self-criticism can distort individuals' perception of themselves. This may partly be a result of including psychotherapy studies, since the therapy experience is influence by the therapy model. Therefore, it is unsurprising that this finding fits with current psychological theory, such as cognitive therapy, which proposes that distorted cognitions can influence how a person views themselves, others and the world, influencing their mental health (Beck, 1967). The distorting nature of self-criticism also has implications for how it can be accurately clinically assessed, as well as captured and measured in research. This review found that therapy changed an individual's awareness of previously unknown aspects of their experience of self-criticism, which could impact how a person scores on self-criticism measures. For example, a higher score indicating increased presence of self-criticism could instead capture an increased awareness.

Several measures of self-criticism exist (for a review, see Rose & Rimes, 2018). Measures of self-criticism have frequently been developed from a clinician's perspective through clinical experiences which may contain valuable insights into phenomena but may contain their own biases. For example, Gilbert et al.'s (2004) commonly used 'Forms of self-criticizing/attacking and self-reassuring scale' (FSCRS), was developed through clinicians' experiences in practice. Another commonly used measure, the 'Self-compassion scale' (Neff, 2003), was developed using focus groups of non-clinical university students who answered questions about self-compassion. Little is known about how the wider population of mental health service users' experiences map onto such measures. This may mean that the

measurement of self-criticism could miss, magnify or minimise important aspects of individuals' experience. This has implications for the validity of measures and is an important area for future research.

Additionally, the association in the West between self-criticism and self-compassion may not hold across cultures. One of the reviewed studies was conducted in Turkey and noted that the concept of self-compassion does not exist in Turkish culture, where the word 'compassion' also holds different meanings (Bayir & Lomas, 2016). Since self-compassion and self-criticism may often be researched together and therapeutic interventions for self-criticism often aim to increase self-compassion (Wakelin et al., 2022), this has potentially large research and clinical implications for conducting culturally relevant and sensitive work in this area.

Some evidence also exists suggesting there may be important cultural and religious differences in the way problematic self-criticism presents. Feinson and Meir (2014) found that self-criticism strongly predicted problematic eating behaviours for Israeli Jewish women but not for Arab Muslim women. Aruta et al. (2021) found that the association between self-criticism, and depression and anxiety, was found to be weaker in individuals from the Philippines. While this may partly be a measurement issue, as already discussed, Aruta et al. (2021) suggest self-criticism plays an important cultural role maintaining social harmony within their interdependent culture. Heine et al. (2000) found that Japanese students rated higher on self-criticism measures than Canadian students, where self-criticism is related to a desire for social harmony and connectedness with others in Japanese culture. This has implications for the findings of this review, whereby the origins, qualities, impact and functions of self-criticism will have generalisability limits. The experience of self-criticism may vary greatly between cultures and religions, highlighting important areas for future research.

This review also suggested that many aspects of individuals' experience of self-criticism may rest outside their awareness, or that their awareness of them in specific ways only became accessible through psychotherapy. Additionally, some individuals expressed their self-criticism was at times deliberate, but at times automatic and habitual and hard to control. The 'broad definition' of self-criticism cited earlier in this study (Kannan & Levitt, 2013) considered self-criticism as within an individual's conscious awareness, and therefore may not be broad enough.

4.4. Clinical implications

This review found that individuals experienced the origins of their self-criticism as directly linked to experiences of criticism by others. The key role that others play in the development and maintenance of individuals' self-criticism may be a key consideration in clinical practice, to not risk individualising wider familial, cultural, societal and systemic issues. Practice which considers formulating and intervening with critical others at organisational, teams and family systems levels may be important areas to consider.

Another finding was that for some individuals, their experience of self-criticism increased following receiving a physical or mental health diagnosis, which was also related to their experiences of stigma. This fits with evidence suggesting that receiving a mental health diagnosis can be a complex process for individuals to manage, which can result in experiences of stigma and discrimination (Perkins et al., 2018). Self-criticism has been linked to difficulties adjusting to illness following cancer (Campos et al., 2012). One implication for clinical practice may be assessing and considering the impact of receiving a diagnosis on an individuals' self-criticism, and the subsequent impact of their self-criticism on managing their difficulties. For example, this could include highlighting that people can be really hard on

themselves following a diagnosis and considering signposting to local support groups or resources.

This review also highlighted the harsh, abusive, and vicious qualities of individuals' self-criticism on an experiential level. Individuals' experiences in research could be used in supervision and in training programmes, to support practitioners to understand and connect with the difficult lived experience of excessive self-criticism.

It was also identified that individuals may hold particular myths, beliefs and misconceptions about self-criticism and self-compassion. In practice, these could be assessed and possibly addressed through psychoeducation and explored in therapy.

A key finding from participants and study authors was that participants were often unaware of several elements of their self-criticism prior to undergoing therapy, which suggests practitioners have an important role to play. Practitioners could also hold useful insights into clients' experiences of self-criticism. However, little is known about how practitioners understand and work with people experiencing self-criticism in practice, beyond the studies identified here, and quantitative intervention efficacy studies. Future research could investigate how practitioners understand and work with people experiencing self-criticism in practice, which could support the delivery of effective, targeted interventions.

4.5. Conclusions

This review aimed to identify studies investigating individuals' experiences of self-criticism and provide a synthesis of findings. Using thematic synthesis, four central themes were identified regarding the origins and triggers, qualities, impacts and survival, motivating or moralising forces of self-criticism. A need for definitions of self-criticism to more fully recognise its diverse origins, as well as differing and dynamic experiential features was highlighted. The review's strengths, limitations, research and clinical implications have been

discussed along with recommendations for future research. One area for future research is to better understand how psychological therapists understand and work with self-criticism.

5. References

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Kirstie Stanworth, BSc (Hons), MSc, PGCert

UNDERSTANDING SELF-CRITICISM FROM PERSONAL AND PROFESSIONAL PERSPECTIVES

SECTION B:

HOW DO UK CLINICAL PSYCHOLOGISTS UNDERSTAND SELF-CRITICISM IN PRACTICE? A GROUNDED THEORY STUDY

Word Count: 7954 (282)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

DECEMBER 2022 (March 2023)

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Objectives: Self-criticism is a transdiagnostic component in mental health which may develop from childhood and likely underpins a variety of psychological difficulties. This study aimed to investigate how clinical psychologists understand and work with self-criticism in practice.

Design: Semi-structured interviews were used to collect data, which was analysed using grounded theory.

Methods: Ten UK-based clinical psychologists were recruited via social media. Individual semi-structured interviews were conducted. A draft model was sent to participants for respondent validation and feedback was incorporated into the finalised model.

Results: Self-criticism was understood to be common in mental health yet exists in a "blind-spot". Participants' personal and clinical experiences of self-criticism and difference affected how they understood self-criticism to have "personal" or "shared" influences. This affected how participants recognised the size and influence of clients' self-criticism, how: "core and deep" it was; the purpose; impact; and link to clients' risk. Participants used their intuitive "clinical gut" to work with self-criticism to integrate models and ideas, moving between working on self-criticism and other difficulties, affecting "movement in the self-critic". This fed back and in turn influenced the size and influence of clients' self-criticism.

Conclusions: Implications and recommendations for future research were discussed, including some specific ways in which self-criticism linked to client's risk. Cultural, structural and societal causes and impacts of self-criticism may be under recognised in theoretical models.

Keywords: Self-criticism, transdiagnostic, experience, clinical psychology practice

1. Introduction

Transdiagnostic approaches to mental health identify common phenomena occurring between individuals and beyond diagnostic categories (Krueger & Eaton, 2015). Identifying and researching transdiagnostic components in mental health could hold important information regarding vulnerability, maintenance and interventions for both simple and complex psychological presentations (Krueger & Eaton, 2015; Nolen-Hoeksema & Watkins, 2011). Self-criticism is an identified transdiagnostic component in mental health and wellbeing and is suggested to influence the risk and maintenance of psychological difficulties (Kannan & Levitt, 2013; Schanche, 2013).

1.1. Self-criticism

A commonly used definition of self-criticism is that it is *"A conscious evaluation of oneself that can be a healthy and reflexive behaviour, but also can have harmful effects and consequences for an individual*" (Kannan & Levitt, 2013, p.1). However, this does not account for evidence that self-critical phenomena may not always be under conscious control (Stanworth, unpublished). Excessive self-criticism has been associated with increased psychological distress for individuals given diagnoses such as depression (Ehret et al., 2015); social phobia (Cox et al., 2004) and borderline personality disorder (Kopala-Sibley et al., 2012). Self-criticism has been associated with psychological distress when managing physical health conditions (Geller et al., 2021; Kauser et al., 2022) and increased risk of self-harming behaviours and suicidal ideation (Gilbert et al., 2010; O'Neill et al., 2021). Higher levels of self-criticism appear to impact the therapeutic alliance (Whelton et al., 2007), and also predict poorer therapeutic outcomes (Löw et al., 2020). Due to the above, self-criticism can significantly impact upon psychological wellbeing, safety and clinical outcomes, where developing knowledge in this area has direct relevance to clinical practice.

1.2. Psychological therapies in the UK clinical psychology profession

As part of their training, clinical psychologists within the United Kingdom (UK) are taught to draw upon a variety of evidence-based models to enable them to develop complex formulations and interventions (British Psychological Society (BPS), 2017a; Health and Care Professions Council (HCPC), 2015).

Various psychological therapies are recommended for use in the UK by the clinical psychology profession, through organisations such as the BPS, and through evidence based clinical guidance from the National Institute of Health and Care Excellence (NICE). This includes but is not limited to: acceptance and commitment therapy (ACT) (BPS, 2017b; NICE, 2021); cognitive analytic therapy (CAT) (BPS, 2016); cognitive behaviour therapy (CBT) (BPS, 2012, 2020; NICE, 2020, 2022); compassion focussed therapy (CFT) (BPS, 2022a); schema therapy (BPS, 2021b); and short-term psychodynamic psychotherapy (NICE, 2011, 2022).

Johnstone and Dallos (2013) also note a trend towards therapeutic integration, where therapies may borrow ideas and concepts from one another. Theoretical frameworks underlying psychological therapies may significantly overlap or offer contrasting explanations of psychological distress and wellbeing, and it is not known how practitioners manage this conceptual confusion (Collard, 2019).

Little is known about how and to what extent practitioners develop unique complex client-centred integrative formulations where people may hold multiple diagnoses (Dallos et al., 2013) despite it being a key component of clinical psychologists' roles (BPS, 2017a). This might not sit naturally within popular research paradigms, which typically heavily rely on sample homogeneity, and rigid application of manualised interventions within randomised controlled trial designs (Margison et al., 2000).

The variety of available psychological therapies, their conceptual overlaps and the uncertainty regarding how psychologists are conducting complex integrative work highlights a significant gap in the literature.

1.3. How psychological therapies conceptualise self-criticism

The possible conceptual confusion regarding psychological therapies extends to how self-criticism is understood (Collard, 2019). No one theory or understanding of self-criticism exists (Chang, 2008; Shahar, 2015). Additionally, self-criticism may not be a specific target for therapeutic interventions, or self-criticism may be viewed differently across psychological models.

Researchers have summarised and reviewed different conceptualisations of self-criticism in psychological theory (Bergner, 2013; Chang, 2008; Kannan & Levitt; 2013; Schanche, 2013; Shahar, 2015). However it should be noted that overarching psychological theories, such as attachment theory (Bowlby, 1973) have influenced the development and use of specific modern psychological therapy models (Thompson et al., 2022). Attachment theory posits that children and their caregivers form specific attachment relationships which are distinct from other close relationships. Caregivers' attunement to their child impacts their ability to meet the child's needs consistently and provide safety and security. Through attachment relationships, a child's internal working model of themselves and other people is developed (Kim et al., 2020). For example, individuals who experienced caregivers as critical are more likely to be self-critical in comparison with individuals who experienced parental warmth (Irons et al., 2006). The development of an insecure attachment relationship style has therefore associated with experiencing high levels of self-criticism (Thompson & Zuroff, 1999; Cantazaro et al., 2010).

Specific psychological therapy models such as Beck's (1976) cognitive therapy expands on overarching attachment theory ideas, explicitly recognising the role of self-criticism in the development and maintenance of depression. Beck proposed that an individuals' early life experiences affect the development of cognitive structures, 'core beliefs' which organise information to make sense of one's experiences. Beck identified the negative cognitive triad, observing that individuals may hold critical views of themselves, others and the world. Self-criticism was viewed as a 'faulty' cognitive appraisal of oneself that developed through difficult early childhood experiences, linked to individuals' core beliefs.

Blatt's (1974) psychodynamic perspective also explicitly considered self-criticism as a key component of depression. Blatt also considered the mechanism behind self-criticism to be rooted in childhood experiences of demanding, critical, and harsh parents. However, in contrast, rather than conceptualise self-criticism as a cognitive process, Blatt viewed the internalisation of critical others as part of one's personality structure, which linked to feelings of inferiority, guilt and worthlessness. Consequently, individuals were proposed to use self-criticism in their striving for perfectionism. Both Beck (1976) and Blatt's (1974) theories were also developed originally for individuals experiencing depression only.

Gilbert's (2009) CFT however is a transdiagnostic therapy model, designed for people experiencing self-criticism and shame, explicitly viewing self-criticism as a transdiagnostic concept in mental health. CFT also links the development of self-criticism to early childhood experiences, however, also proposes other mechanisms, viewing psychological distress within a social evolutionary neuropsychological framework. Gilbert (2009) proposes three affect regulation systems: the drive, threat and soothing systems. Individuals high in self-criticism may have an overactive threat system due to past experiences, and as a consequence, a very active drive system to avoid rejection and compete for status and

resources. Perceived failure to achieve can result in self-criticism, in turn reactivating the threat system. Overactivation and hypersensitivity of threat and drive systems is typically also associated with under activated or an underdeveloped soothing system, where individuals may struggle to generate self-compassion and feelings of safeness.

To add to possible confusion, other approaches such as ACT (Hayes et al., 2016) or narrative therapy (White & Epston, 1990) offer overarching transdiagnostic explanations of psychological distress and wellbeing. Although self-criticism is not specifically conceptualised as part of their theoretical models, transdiagnostic techniques are instead offered for working with self-criticism, such as defusion (Harris, 2019) and externalisation (Coaston, 2020).

There may also be a need to re-examine many existing therapy models in light of other broad theoretical understandings of human distress, such as the Power Threat Meaning Framework (Johnstone et al., 2018), minority stress models (Meyer, 2013), critical community psychology (Kagan et al., 2019), positive psychology (Hefferon & Boniwell, 2011), and work to decolonise psychology (Bhatia, 2017; Cullen et al., 2020) which may also inform clinicians' work. Though these theories do not necessarily conceptualise self-criticism, they do offer different approaches to conceptualising psychological distress and wellbeing which could possibly in turn influence the conceptualisation of self-criticism.

1.4. Aims and rationale

A key part of psychologists' roles is the knowledge, application, and integration of approaches. Clinical psychologists may have access to lots of different conceptualisations of psychological distress and self-criticism. However, little is known about how self-criticism is understood and worked with in practice. This novel exploratory study aims to address the gap in the literature to theorise how UK based clinical psychologists understand and work with

self-criticism in practice. The aim of this study was to investigate “how do clinical psychologists understand and work with self-criticism in practice?”.

2. Methods

2.1. Design

A qualitative grounded theory methodology (GTM) employing semi-structured interviews was used due to the understudied nature of this topic (Creswell, 2007). Corbin and Strauss’s (2014) procedures were chosen to enable a systematic process for theorising from the data (Strauss & Corbin, 1998). The research epistemological stance was critical realist, which posits there is an objective reality present independent of oneself, where it is also impossible to step outside one’s own perspective (Oliver, 2012).

2.2. Participants

Ten qualified UK based clinical psychologists took part in the study (Table 1). Three further people expressed interest in the study, however, did not respond to invitations. Participants’ ages ranged from 31 to 57 years, (Mean = 38.7 years), with years since qualifying ranging between 2.5 to 24 years (Mean = 8.5 years). Participants sexualities were reported as heterosexual (*n* = 7), gay (*n* = 1), lesbian (*n* = 1) and pansexual (*n* = 1).

2.3. Procedure

Participants were recruited using purposive opportunity sampling via adverts (Appendix D) placed on social media sites and through word of mouth. Inclusion and exclusion criteria were employed (Table 2) however this was used flexibly. For instance, the cut-off of three years post-qualification was intended to include participants with sufficient experience to discuss the study topic and exclude newly qualified psychologists who may be consolidating knowledge (Rønnestad & Skovhalt, 2003). One participant was accepted to the study with 2.5 years’ experience. Psychologists working with children only were excluded to

narrow the field of research, due to the diversity, ongoing development and associated ways of working with this client group.

Table 2.

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Qualified accredited clinical psychologists with three or more years clinical experience post-qualification (flexible) • Working in adult services with people over 18 years old • Worked with people who had experienced significant self-criticism which was a recent focus of the clinical work	• Trainee clinical psychologists • Newly qualified clinical psychologists • Other psychological and healthcare professional roles • Working with children only

Table 1.

Anonymised participant demographics

Participant order and pseudonym	Gender identity	Ethnicity	Religion	Current service description
1 - Emily	Female	White British	None	Private outpatient clinic
2 - Charlotte	Female	White British	None	Secondary care community mental health service
3 - Kaitlin	Female	White Northern Irish	Catholic	Psychotherapy service and community learning disability team
4 - Adam	Male	White British	None	Specialist health service – inpatient and community
5 - Victoria	Female	White British	None	Neurorehabilitation service
6 - Jessica	Cis Female	White British	None	Adult forensic service
7 - Rosalie	Female	White British and French	Atheist	Specialist health service
8 - Arya	Female	Indian British	Hindu	Early intervention in psychosis service
9 - Hannah	Female	White British	Atheist	Secondary care community mental health team
10 - Oliver	Male	White British	None	Early intervention in psychosis service

Interested participants emailed the author and were sent the information sheet, consent form and demographic screening survey (Appendices E-G). After gaining consent, an online interview was scheduled, and audio recorded. After interviews, participants were debriefed (Appendix H). Upon finalising the data analysis, participants were all emailed the model summary for feedback and respondent validation (Appendix I).

2.4. Data collection, analysis and quality control

In October 2020 a bracketing interview (Creswell & Miller, 2000) was completed with the research team to uncover their preconceptions, assumptions and biases which could influence the project (Corbin & Strauss, 2014). This was recorded and reflected upon in a subsequent session, where this information was considered throughout the project. Quality was monitored using the NICE (2012) qualitative checklist throughout the study and write-up.

An interview schedule (Appendix J) developed with research supervisors and in consultation with the Salomon's advisory group of experts by experience was piloted. Participants were asked to think about a client they had worked with who experienced self-criticism. Ten interviews were completed between July 2021 and March 2022, ranging from 52 to 69 minutes (Mean = 62 minutes).

After each interview, the researcher noted their thoughts about key ideas, themes and questions. Data collection and analysis was completed concurrently in a cyclical process where data collection ceased when theoretical sufficiency was achieved (Dey, 1999). This meant that after each interview, new insights and lines of enquiry were identified. Accordingly, the interview schedule was continually adapted to explore emerging concepts in line with GTM and theoretical sampling principles (Corbin & Strauss, 2014). For example, after four interviews a pattern emerged whereby participants discussed only client work resulting in improved clinical outcomes. Subsequent participants were asked to discuss a client who had disengaged or

experienced other outcomes. Following a particularly rich interview with one participant who considered in depth how self-criticism linked with different diverse layers of social context, the schedule was amended to ask future participants about social contextual factors such as “any other places self-criticism might come from?” and “are there any groups of people you have noticed particularly struggle with self-criticism?”. On another occasion, a participant discussed the link between self-criticism and risk and again the schedule was adapted to ask participants questions such as “How might self-criticism link to risk?”, “Were there any risks for this person?”.

A research diary containing theoretical memos (Corbin & Strauss, 1990), annotations, notes and diagrams was used throughout the process and for quality evaluation. Supervisors viewed interview transcripts and commented throughout coding and model development. Appendix K-O provide examples of the data analysis process.

The first five interview transcripts were open coded, initial concepts were labelled and constant comparison was used to consider similarities and differences both within and between interviews (Corbin & Strauss, 1990). Axial coding using diagrams was completed with all transcripts to discover patterns and relationships between concepts before selective coding unfolded to generate the overarching core categories and subcategories. Finalised categories were agreed by the research team before a model summary was sent to participants for feedback (Appendix O). Six participants provided feedback via email on the proposed model which was incorporated into the final model (Appendix P).

2.5. Ethical considerations

Ethical approval was granted by Salomon’s Institute for Applied Psychology ethics panel (Appendix Q). The study was conducted in accordance with BPS (2021b), HCPC (2015)

standards and NHS values (Department for Health & Social Care, 2021). A study summary was sent to the ethics panel following study completion (Appendix S).

Participants were provided with information about the study, data handling, confidentiality, and their right to withdraw or terminate interviews at any time. Participants were given the research team and university contact details and details of support organisations in the debrief sheet if needed.

Participant information was used in accordance with General Data Protection Regulation (2016) guidelines. A document linking participants' names and unique identifier numbers was password protected in a separate file to their data. Transcript data were anonymised and only accessible to the research team. Interview recordings were deleted after transcription.

3. Results

3.1. Model overview

Table 3 presents an overview of developed categories. Five core categories were developed from the analysis, along with ten subcategories. Figure 1 presents the overarching model and its interactions. Each category and its relationships will be described along with anonymised participant quotes using pseudonyms. Duplicate words and "ums" have been taken out of quotes for clarity.

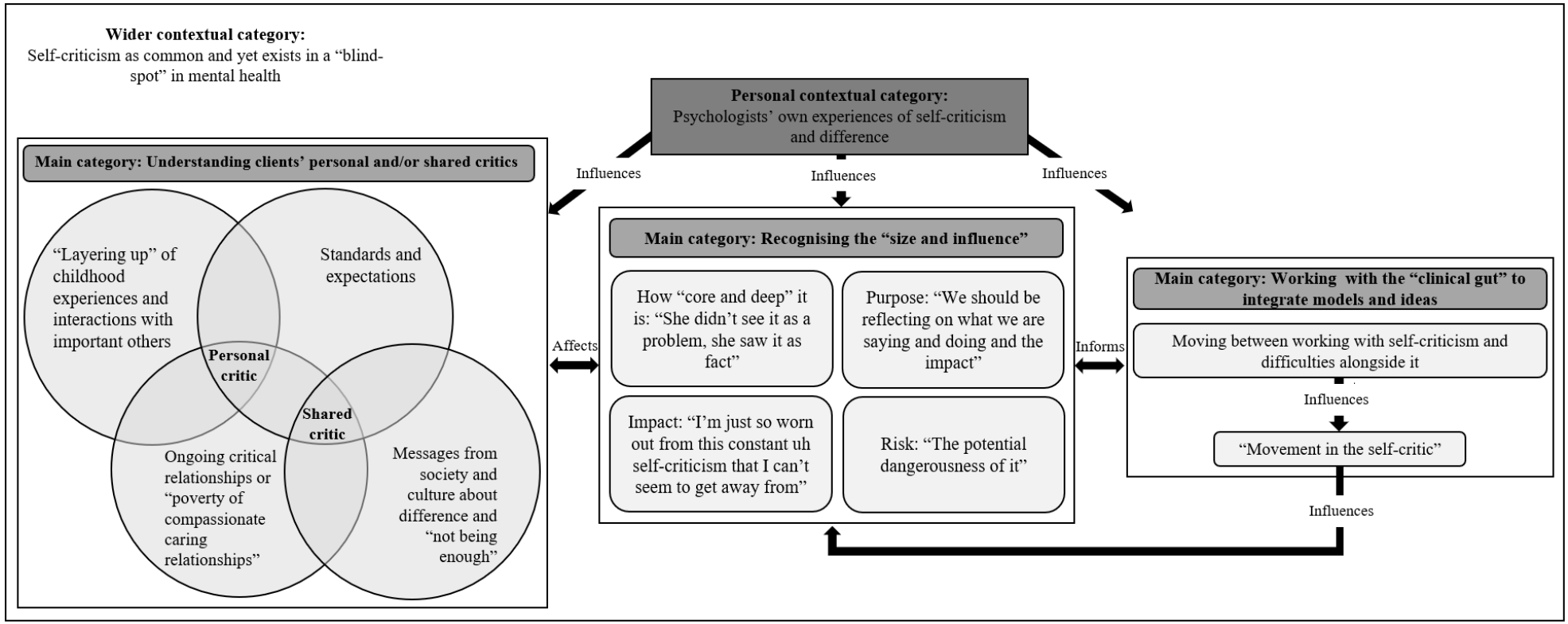
Table 3.

Summary of categories

Core categories	**Sub-categories**
Wider contextual category: **Self-criticism as common and yet exists in a "blind-spot" in mental health**	
Personal contextual category: **Psychologists' own experiences of self-criticism and difference**	
Main category: **Understanding clients' personal and/or shared critics**	The subcategories for this category overlap: • "Layering up" of childhood experiences and interactions with important others • Ongoing critical relationships or "poverty of compassionate caring relationships" • Standards and expectations • Messages from society and culture about difference and "not being enough"
Main category: **Recognising the "size and influence"**	• How "core and deep" it is: "She didn't see it as a problem, she saw it as fact" • Purpose: "We should be reflecting on what we are saying and doing and the impact". • Impact: "I'm just so worn out from this constant uh self-criticism that I can't seem to get away from" • Risk: "The potential dangerousness of it"
Main category: Working with the "clinical gut" to integrate models and ideas	• Moving between working with self-criticism and difficulties alongside it • Movement in the self-critic

Figure 1.

Developed model of how clinical psychologists understand and work with self-criticism



3.2.Wider contextual category: Self-criticism as common and yet exists in a "blind-spot" in mental health

This category captures the reflections from all participants that self-criticism was felt to be a common human experience noticed in themselves and in clients, *"I think it's such a common problem […] in all our client work, it's absolutely there and either the sort of doing too much of it or not doing enough of it"* (Kaitlin). However, self-criticism was felt to exist in a blind-spot for psychologists, clinical training and the medical model, hence this category is positioned as context for the model.

All participants expressed they had not thought about self-criticism in such detail before the interviews. Several participants suggested this might represent a "blind-spot" in the wider diagnostic focused medical model organising mental health care:

> "*Self-criticism isn't an illness so whereas I think anxiety, depression and obsessiveness […] get kind of easily framed as "illnesses" self-criticism doesn't so it's kind of a sidestep from the medical model kind of approach possibly something about how universal it is and so maybe it sort of gets minimised or dismissed*" (Oliver).

This blind-spot also extended to clients: *"People don't kind of come to you and say I'm really critical about myself and I want to change it, it's almost like that's something that comes out when you start getting to know someone"* (Jessica).

Two participants posited the possibility that the nature of clinical training and the difficult route to qualification may select high achieving people who may not be aware of their own self-criticism, leading to a possible blind-spot in the profession as a whole:

> *"Psychologists are all kind of I don't know overachievers and I would relate that to the high self-criticism so and that could be an interesting reason why*

psychologists might not be so well equipped to work with it or recognize it 'cause we might it might be a bit of a blind-spot" (Oliver).

All psychologists noted that they had not directly learnt about self-criticism on their training courses or in their qualified roles. All participants had sought out CFT and/or ACT training to work with self-criticism.

3.3. Personal contextual category: Psychologists' own experiences of self-criticism and difference

Affected by the wider context above, this category encapsulates a key concept where participants described how their personal experiences of self-criticism and difference appeared to affect how they understand self-criticism and how they work with it:

"[Talking about in comparison to using CBT] I've got my doctorate, […] I'm now a consultant none of that has updated that part of me that thinks I'm incompetent, and I think that's where ACT wins because I don't have to challenge that part I just have to know it's there" (Emily).

One participant reflected feeling their own experience of working on self-criticism in therapy helped them practice more authentically: *"I've got quite high levels of self-criticism and I've been in my own personal therapy ever since training would not be without it […] helped me I think more authentically then support clients without self-disclosing too much"* (Victoria).

One participant explicitly situated their experiences of self-criticism within a social constructionist framework due to their experiences of being in minoritized groups:

"*[Talking about dyslexia] I think my own experience with the self-critic is like a very long history and it probably stems from not being able to read until I was*

about [pre-teens: exact age removed for anonymity] and being queer and not being understood and feeling that something was wrong" (Adam).

This participant had a notably different rich understanding of self-criticism as being linked to various personal and societal factors (3.4), compared to other participants who did not discuss holding many personal or clinical experiences of working with difference: *"I guess like I don't know from my personal position […], I guess I hold a lot of more kind of privileged positions"* (Emily) and *"I'm really conscious that in my qualified work the client groups I've been working with have not been very diverse"* (Victoria).

However, four participants noticed a link between self-criticism, and difference and diversity in the client groups they worked with, briefly noting how wider contexts such as racism and transphobia impacted on clients' self-criticism: "*[Talking about self-criticism in Black men] They've spoken about kind of always feeling observed or watched or kind of inferior in some way"* (Arya) and "*[Talking about working with gender diverse clients] A lot of self-criticism about appearance about body about not fitting in with sort of gender stereotypes and I think that's probably a population within society […] with very high levels of self-criticism"* (Jessica).

3.4. Main category: Understanding clients' personal and/or shared critics

Four sub-categories were identified which participants linked to the development of one's self-critic. Participants' experiences of self-criticism and difference (3.3), along with the client they discussed, affected the weight they placed upon these areas. Figure 1 shows that these concepts heavily overlapped in discussions, identifying areas which might contribute to the concept of a "personal critic" and areas which contribute to a "shared critic".

3.4.1. "Layering up" of childhood experiences and interactions with important others

The majority of participants saw problematic self-criticism as stemming from a person's own early childhood experiences, attachment figures or trauma, usually with parents and caregivers: *"Childhood experiences strong figures […] as children nothing they did was good enough […] but also where in adults who were children and they everything they did was perfect they were perhaps overindulged"* (Victoria).

Several participants extended this to a child's wider social relationships, including experiences of bullying by peers and relationships with teachers:

> *"Important attachment figures, primary caregivers […], authoritative figures, and so thinking about teachers or any other kind of nursery staff or anything basically any voices from that were important to them that they sort of internalized or had a sense of respecting"* (Hannah).

3.4.2. Ongoing critical relationships or "poverty of compassionate caring relationships"

Participants described situations where clients had ongoing relationships with critical caregivers or were in ongoing relationships with critical others, feeding into their personal self-critic: *"It's probably come about through just him falling into a similar relationship with somebody who is very critical"* (Emily). This maintained clients' self-criticism, affecting the size and influence of the self-critic (3.5), "*The only source of any sort of relational contact is with his family who he experiences as just rejecting of him and that he's a burden and a nuisance not good enough so he just keeps returning to that"* (Kaitlin).

3.4.3. Standards and expectations

Participants linked their own and clients' self-criticism, to standards and expectations of oneself and/or from others, which was often rooted in family and school contexts: *"High perfectionist standards […]we have to give everything 110% my dad always worked really hard even when he was ill, and therefore I should be able to do that"* (Rosalie) and *"High expectations about what it was to be a child at this school and then there was a disparity for her in terms of her experience at boarding school and then when she was home in the holidays"* (Hannah).

Two participants talked about standards within their clients' employment contexts in the police and military influencing their self-criticism:

> *"They were in the police, so I think there is something there about having kind of having high standards about the self and being able to cope as well […] they were a victim of something in their personal life and they felt like I shouldn't have been the victim because I'm a police officer"* (Jessica).

> *"The military is by very nature quite aggressive you have to, they have really exacting standards way above any other sort of domain possibly, because it's so sort of safety critical, […] self-criticism very much kept them at the standard they needed to be, and whereas in more everyday civilian life that would be unhelpful"* (Victoria).

3.4.4. Messages from society and culture about difference and "not being enough"

Most participants primarily viewed self-criticism as stemming from early childhood experiences (3.4.1) and were able to talk in richer detail about this than societal aspects of difference. This is influenced by participants' experiences of working with difference (3.3). However, as discussions unfolded, most participants noticed a link between self-criticism and

societal messages, including wider norms and societal milestones *"Just depending on the society you're in and what kind of rules or laws are in place"* (Oliver).

These societal messages and the individuals' associated self-criticisms could be different for different groups of people, such as: women "*Not being the perfect mother, wife, friend, sister"* (Hannah); and queer and gender diverse people *"Internalized transphobia in a way that […] I'm like there's something wrong with me for being this way […] being surrounded by this narrative that it's a bad thing to be trans"* (Jessica), where heteronormativity is assumed *"Societal assumptions around heteronormativity, […] get you being critical about your own self experience, which might be quite non heteronormative"* (Adam). For some groups of people experiencing similar critical societal messages, the concept of a shared critic was put forward: "*You can share critics in a way that you wouldn't if you were in a different community"* (Adam).

Messages given by potentially positive representations of groups through role models were also viewed as feeding into self-criticism "*Dyslexic role models around there, there's an idea that, oh, "I just pushed myself really hard""* (Adam) and "*The Paralympics can be quite shaming you're not if you're not someone who can run and get a gold medal who are you?"* (Adam).

Self-criticism was linked to shame, criticism from others, and social stigma someone might receive as a result of these societal messages: "*Shame around living with disability and chronic illness and a kind of social stigma of living with an invisible condition"* (Rosalie) and "*HIV when it wasn't necessarily as treatable as it is now, and having high levels of shame and stigma"* (Adam) and "*They're in an open relationship and that's normal for them, but the criticism they experience around that from others"* (Adam).

These messages culminated in clients' self-criticism being linked to experiencing messages of being less than others and feeling that they weren't enough "*Social like deprivation, kind of racism, discrimination, those kind of things as well I think if you've grown up feeling less than others"* (Arya), where self-criticism might be underlying a need to prove one's worth*"[Talking about a client who immigrated to the UK] This kind of perpetual sense of you know I've done well and I gotta do better I gotta stay here"* (Emily).

3.5. Main category: Recognising the "size and influence"

Participants' understanding of their clients' personal and shared critics affected how they were able to recognise the size and influence of clients' self-criticism.

3.5.1. How core and deep it is: "She didn't see it as a problem, she saw it as a fact"

For some participants, they spoke about clients who had experienced years of entrenched self-criticism *"It feels like you're going against a sort of lifetime it's almost like a sort something so kind of core and deep"* (Oliver). For others, problematic self-criticism might have been activated and increased following a life event, such as experiencing a health problem: *"Clients who feel their strokes would be down to lifestyle choices or pre-existing stress/ self-criticism particularly vulnerable"* (Victoria).

Participants spoke of entrenched problematic self-criticism as seen as "*Fact*" (Emily) being unfair, often unquestioned, unrealistic and inflexible, "*They're quite abrupt like they're quite sharp, they're quite final, they really they can be quite fixed as well"* (Arya). This meant that for some clients the thought of changing or questioning the self-critic was immensely difficult *"To get rid of this or not even to get rid of it, but to entertain an alternative is really scary"* (Adam), which could provoke an intense emotional response *"Was almost a sort of disgust reaction she would have at the idea that she would even attempt to be less self-critical of herself"* (Oliver). The impact (3.5.3) affected clients' experience of therapy and

subsequent engagement *"When she did start to do that in sessions it became far too emotionally overwhelming for her"* (Hannah).

3.5.2. Purpose - "We should be reflecting on what we are saying and doing and the impact"

All participants thought about the purpose of self-criticism for client(s) and self-criticism as serving a protective function, usually in the context of early childhood experiences of criticism and/or trauma: "*I see it as a really adaptive way of living with in an adverse situation […] so it might be really adaptive to be really quite critical of yourself if […] that keeps you safe"* (Adam) and *"The intention is to protect the person from further hurts by just expecting criticism and anticipating it and then telling yourself that really this is what happens in relationships"* (Kaitlin). Self-criticism was further noted to be functional in police and military work contexts (3.4.3).

All participants began discussing self-criticism as a problem or difficulty, however later on in the interview several participants described thinking about self-criticism as a continuum, "*Some self-criticism could be helpful I never really thought about it before, but could be helpful in terms of shaping behaviour"* (Charlotte), where it serves an important social function:

> *"We should be reflecting on what we're saying and doing, and the impact of that on other people, so if we do something that is offending somebody we need to be able to think about that and think about the meaning of that"* (Kaitlin).

When participants viewed self-criticism on a continuum, they thought about what the wider purpose of self-criticism might be through considering what minimal or absent self-criticism might look like:

"Like a narcissist basically someone who can't self-correct always thinks that others are sort of responsible for their shortcomings and it becomes very hard to sort of learn or develop yourself or your behaviours, because the thought isn't going into your mind that oh actually I might be doing something a bit wrong here" (Oliver).

3.5.3. Impact: "I'm just so worn out from this constant self-criticism that I can't seem to get away from"

All participants' spoke about the significant varied impacts of self-criticism*:*

"It affects their mood, it reduces their confidence […], they're less willing to try new things or different things, and the belief that they won't manage it, people often don't feel very worthwhile, they belong, or have a place in the world" (Charlotte).

Self-criticism also impacted specific difficulties, such as managing a physical health condition: "*Self-criticism normally comes up as the biggest barrier to self-management"* (Rosalie).

Self-criticism was understood to have a huge emotional impact on clients, *"With self-criticism there's like an energy to the emotional content of what they're saying and it feels very powerful towards the self like quite destructive"* (Arya). Shame was thought to be the emotion that *"Kind of envelopes"* (Emily) the self-critic, influencing mood *"There's lots of shame there's lots of depression, […] not being good enough being and useless, worthless"* (Kaitlin) and amplifying emotions: "*It increases magnifies anxiety and depressive kind of symptoms people end up doing less in their lives"* (Charlotte), and *"I wish I wasn't doing it to myself, but I can't seem to stop it and then he beats himself up about that"* (Kaitlin).

Self-criticism in particular was thought to impact how clients viewed the world, through a *"Veil of negativity and self-criticism"* (Kaitlin), where a stuckness was identified,

linking to clients filtering information congruent with their self-critical view: *"Good feedback gets screened out or it gets just downplayed or dismissed or just not even noticed so there's no potential for some different feeling about the self to be experienced […] it's a stuckness"* (Kaitlin). This impacted individuals' relationships with themselves: *"How horrible she speaks to herself and like you wouldn't speak to anyone else like that"* (Jessica) and with others "*Problematic to relationships it made them perhaps a hard person to spend lots of time with"* (Oliver). This linked with 3.4.2 where the impact of self-criticism may also keep someone in relationships with critical others.

This veil further impacted how people engaged with therapy *"If we do any work processing this trauma, I think it's going to be through the lens of self-criticism and it will be unhelpful for the person"* (Charlotte), *"She was even self-critical about therapy and how she would perform in therapy and if she was doing it right*" (Arya).

3.5.4. Risk: "The potential dangerousness of it"

Linked to how core and deep the self-criticism was (3.5.1) and the impact (3.5.3), participants described self-criticism as underlying or linked to clients' suicidal thinking:

> *"There's not a lot of value in carrying on like this they're constantly kind of critical of themself and others and just sitting just seeing very little to feel kind of optimistic about or little there's little joy in anything*" (Oliver)

Self-criticism was also linked with self-harming behaviours "*He's had a very extensive self-harm history, which I think the critic comes into"* (Jessica)*;* harm towards others "*Getting into fights, arguments"* (Jessica); risky sexual behaviours "*I think it led to her putting herself in situations where she quite enjoyed being punished"* (Hannah)*;* dangerous eating behaviours *"She had disordered eating that was having quite a significant impact on her physically"* (Hannah)*;* and substance use *"She's got into accidents or pissed off her*

family and then she's in this spiral of shame and guilt and being very punitive towards herself for having drunk" (Hannah).

3.6. Main category: Working with the "clinical gut" to integrate models and ideas

A common concept for all participants was the ability to use one's "*Clinical gut"* (Adam) to work in an intuitive client centred way to integrate ideas they felt often overlapped. This clinical gut was understood as developing over time with experience: *"I've given myself permission to actually go with sort of a more client centred approach in my mind […] with more experience as I've had different conversations with different clients and learnt more about them and what's worked"* (Victoria).

All participants described using a client centred approach, having one or more 'go-to' formulations or approaches *"My sort of go to formulation would be that kind of like longitudinal CFT one"* (Emily) based on their personal and/or service preferences *"I would use a schema informed model to work with people and I'd also think, systemically and I also use the CAT informed model too"* (Hannah).

Participants flexibly changed approaches as needed, tending to use an overarching model or models to formulate clients and their self-criticism, where the intervention could also consist of using another model or models:

> "*[Talking about schema therapy] It's just very in its nature it's very integrative […], so there's some cognitive stuff and behavioural stuff, so it's very flexible […] schema uses like a lot of imagery and a lot of chair work and which are more like emotion focused techniques and compassion focused therapy uses a lot of that well, I've so that's something I think I try and integrate a little bit, more recently I've been trying to think about bringing a bit of EMDR"* (Jessica).

Participants described their ability to integrate models as being linked to noticing similarities between models:

> *Different models have different ways of talking about that but it's this sort of same thing, negative self-talk is the negative parental voice, harsh superego it's some object some experience of another person that is very harsh and very negative has been internalised and is being repeated in relation to the self"* (Kaitlin).

All participants used integrative personalised formulations, considering whether the self-criticism was underlying or contributing to difficulties or diagnoses, *"I think the psychosis is often just a sort of you know by-product of some other things that need to be focused on which might include difficulty with living with self-criticism"* (Oliver) and *"He came in with all those kind of unintended consequences of it he came in with like binge eating"* (Emily).

3.6.1. Moving between working with self-criticism and difficulties alongside it

Linked to 3.2, where self-criticism was viewed as existing within a blind-spot, people were often referred to psychology for other difficulties, such as binge-eating, traumatic experiences, psychosis and managing health conditions. This meant that self-criticism was often understood as interacting with or underlying other difficulties. This led to participants noticing a need to move between working with self-criticism and difficulties alongside it. This also meant sometimes using different approaches for different aspects of the person's presentation "*It's a broadly cognitive EMDR for the trauma work but the criticism work is more around compassion, sitting with, acceptance"* (Charlotte).

Complex trauma work in particular often necessitated work on self-criticism *"Part of the work might be dealing with intrusions and flashbacks and nightmares relating to what's happened, and alongside that you've got the self-criticism"* (Charlotte). For other

participants, client's particular difficulties or diagnoses might take attention over the underlying self-criticism *"[talking about someone struggling with their binge-eating] We had quite a few sessions that were very much more pragmatic around the eating and it definitely felt like you know this isn't I mean, you know it wasn't unhelpful, but this isn't the work"* (Emily).

Several participants also described talking about working with risk (3.5.4) alongside self-criticism work. One participant described a difficulty of holding a tension between working with a client experiencing suicidal thoughts that were also self-critical "*Really dark thoughts including these self-critical ones*" (Oliver) and considering the client's safety and his duty of care often leading him away from discussing the self-criticism *"Services worrying and safety planning and then never really creating lots of opportunity to just stay with the things that are preoccupying him"* (Oliver).

All participants described using CFT ideas and techniques either as the sole model or integrated with other models to work with self-criticism. This was often used alongside ACT techniques. All participants described beginning work by building awareness of clients' self-criticism, often utilising: mindfulness techniques *"You're gonna need to be able to have be aware of when things show up"* (Emily); experiential techniques *"I was trying to bring his awareness into the moment rather than it being an intellectual awareness, be a real kind of experience awareness"* (Victoria); and externalization "*So I say, "oh, it sounds like the "I should do better" is around right now what's that like? How does that get you acting?""* (Adam). A major focus of the work for participants was for the client to begin to hold the critic lightly and change one's relationship with it "*We kind of agreed that it wasn't about giving it up but about just loosening his relationship with it for times where it wasn't serving the purpose"* (Victoria).

Alongside this work, all participants described the importance of developing self-compassion (Victoria) "*I think one of the main things there was just being kind to himself and loving himself a bit more which he found quite emotional".*

The majority of work occurred in individual therapy sessions, however some participants included the team *"We thought about how she might work with other team members too to try out some of the sort of self-compassion exercises and I sort of encouraged her to make different relationships with people in the team"* (Oliver), and used live situations:

> *"In inpatient, I can join in everyday life that gives me so many opportunities […] to actually help someone implement it and recognise it in their day-to-day stuff, and I found that way more powerful than sitting down 50 minutes therapy sessions"* (Victoria).

Only one participant described how they might work with self-criticism placing it within the context of wider society and systemic issues using coordinated management of meanings and power threat meaning frameworks ideas:

> *"Thinking about how self-criticism related to gender norms in society, what that meant, […] how power was operating to create give a great emphasis to the self-critic and […] then how that created certain values that were not necessarily congruent with the other things that he was talking about in his life"* (Adam).

3.6.2. "Movement in the self-critic"

Participants described an uncertainty in the work whereby it was not known if working on other difficulties would generate useful sufficient movement in the self-critic until work was undertaken: *"They could clearly say that I don't hear voices anymore, but I'm still left with that thought, so I'm still left with like the questioning myself"* (Arya) or whether work on other difficulties would affect self-criticism:

> *"As some of the kind of traumatic incidents we were looking at were kind of processed and worked through, the critic seemed to get much smaller and […] a lot of like the adaptive stuff just sort of came through"* (Jessica).

No one used any structured self-criticism outcome measures. Participants described movement in clients' self-criticism as difficult to get a sense of:

> *"Hard to measure the amount to which people negatively like talk to themselves […] You do sort of have to see it in the reflection of that outward behaviour changes and I suppose it depends on what your formulation is and like where the self-criticism like shows up in their life and do those things change?"* (Jessica).

Self-criticism was thought of as something that might reduce but never fully disappear, where one's relationship to it, ability to manage it and the clients' development of self-compassion were key indicators of change *"Maybe it will always be there but actually, it's much smaller and that more compassionate healthy part, being more present has been bigger"* (Jessica). This in turn affected recognising the size and influence of self-criticism (3.5) for participants and clients.

4. Discussion

4.1. Model summary

This study used grounded theory methodology to generate a theory of how clinical psychologists understand and work with clients experiencing self-criticism in practice. The model proposed that self-criticism is understood to be common in mental health yet exists in a "blind-spot". Participants' personal and clinical experiences of self-criticism and of difference affected how they understood self-criticism to have "personal" or "shared" influences. This in turn affected how participants recognised the size and influence of clients'

self-criticism, how: “core and deep” it was; the purpose; impact; and link to clients’ risk. Based on their perception of size and influence, participants used their intuitive “clinical gut” to work with self-criticism to integrate models and ideas, moving between working on self-criticism and difficulties alongside it, affecting “movement in the self-critic”. This fed back and in turn influenced the size and influence of clients’ self-criticism.

4.2.Theoretical implications

The finding that participants viewed self-criticism as common across a range of client groups, presentations and settings, supports the idea of self-criticism as a transdiagnostic concept in mental health (Schanche, 2013). The idea that self-criticism exists in a blind-spot is new. Little research exists which examines the incidence of self-criticism in clinical psychologists, however several small studies suggest clinical psychologists may hold high standards and expectations and perfectionist traits (D’Souza et al., 2011). It is possible this may be due to the long clinical psychology training route which can be time intensive requiring both undergraduate and in some cases, postgraduate degrees prior to three-year doctoral training (BPS, 2022b; Leeds clearing house, 2022). Some research has found high levels of self-criticism in student populations (McIntyre et al., 2018). It could be hypothesised that the profession may experience high levels of self-criticism, however further research is needed to determine the extent and impact of this.

Participants’ experiences of difference were found to impact the way they understood, recognised and worked with self-criticism. The majority of participants disclosed little personal or clinical experiences of working with difference and diversity. This fits with longstanding theories regarding wider societal intersecting systemic issues of discrimination and privilege, such as systemic racism and ableism (Brown & Leigh, 2018; Powell et al., 2022). This may affect who can access higher education and certain professions, including

clinical psychology (Kinouani et al., 2015; Prajapati et al., 2019). This further aligns with research highlighting unequal access to healthcare services (Public Health England, 2018) and psychological therapies for ethnic and sexual minorities (NHS Race & Health Observatory, 2022; Semlyen & Rohleder, 2022). This loss of diverse perspectives and experiences could therefore have significantly influenced clinical psychology research and practice, possibly missing important concepts relevant to working with diversity and difference.

Most psychologists understood self-criticism as linked to attachment and early childhood experiences, often within family or school contexts. This echoes the research, where self-criticism has been linked to adverse childhood experiences and experiences of criticism in childhood and/or trauma (Pagura et al., 2006; Shaver et al., 2017; Werner et al., 2019). Psychological models such as schema therapy provide attachment-based explanations of self-criticism (Young et al., 2006). Though some psychological approaches such as systemic therapy (Suppes, 2022) and the power threat meaning framework (Johnstone et al., 2018) recognise the impact of societal issues, clinical psychology professions have been criticised for individualising wider social problems (Binnie, 2015; Cornish et al., 2018). This may be echoed in this study's findings, where participants only briefly considered societal messages and experiences such as racism, heteronormativity, deprivation and transphobia as impacting self-criticism; aligning with research investigating the minority stress model of mental health for people in sexual minority groups (Meyer, 2013; Hatzenbueler, 2009). Research suggests the relationship between internalised heterosexism and psychological distress is mediated by self-criticism for sexual minorities (Puckett et al., 2015). Self-criticism has been suggested to play a key role in internalised racism (Graham et al., 2016) and coping with racial discrimination (Villegas-Gold & Yoo, 2014). Several studies also suggest that self-criticism may operate differently in different cultures (Aruta et al., 2021;

Yamaguchi et al., 2014). As psychology practice and research have a diversity problem (Daiches, 2010), cultural, societal and structural causes and impacts of self-criticism may be under recognized or addressed in theoretical models. This has major implications for how self-criticism is then understood and worked with in practice.

4.3. Research implications

Participants integrated models using clinical experience to develop tailored personalised formulations and offer integrative interventions with people. Personalised, integrative working may not naturally sit within current dominant quantitative research approaches (Margison et al., 2000). Dallos et al. (2013) proposed that clinicians may develop their own personal therapeutic style through experience, suggesting overarching guidelines for effective integrative formulations. Norcross and Wampold (2018) highlight that no one psychotherapy or theory is effective or applicable to all individuals, suggesting various practice, training research and policy recommendations for transdiagnostic and individualised therapy. This may be more in line with patient centred care approaches to mental health (Independent Taskforce for Mental Health, 2016). However little research exists about this. Future research could focus upon understanding what effective client centred working, effective integrative working and effective transdiagnostic working might look like.

Fairburn and Cooper (2011) highlight that little is known about therapists' ability to deliver therapy. They suggest that research on therapy quality and therapists' competence may be more clinically useful than traditionally used RCT measurements of therapy manual adherence (Barber et al., 2007; Shedler, 2015). Tracey et al., (2014) further state that little is known about the effect of therapist expertise on client outcomes, where research could benefit from investigating the assessment and development of clinical expertise (Hill et al., 2017). Such future research could build upon this study's findings by considering how

psychologists' work with self-criticism could be affected by therapy quality, therapist competency and expertise on client outcomes.

4.4. Clinical implications

One critical finding was the concept that self-criticism could underlie an individuals' risk of harm to themselves or others. This is supported by research finding a link between high levels of self-criticism and increased likelihood of: self-harming behaviours (Zelkowitz & Cole, 2019); suicide (O'Neill et al., 2021); and severe eating difficulties (Kelly & Carter, 2013). Limited research exists around the relationship between self-criticism and harm towards others and thus could be a focus for future research.

These study findings could be used to consider how self-criticism may impact understanding a person's risk in sessions and in reflective practice. One participant reflected that sometimes risk management procedures, whilst crucial for patient safety, might at times deflect attention from the underlying issue which may be self-criticism. One interpretation of this finding might be that a person's risk management plan could link to their personalised formulation and therapeutic plan, alongside the usual safety strategies. It may be that self-criticism could act as a stable and/or dynamic risk factor for some people, impacting their risk management plans (Department of Health and Social Care, 2009). This could be an important area for future research.

More broadly, psychologists are expected to be reflective-scientist practitioners, where a key outcome of reflective practice is the possibility of knowing oneself, limits and biases in order to provide fair practice (Lilienfeld & Basterfield, 2020). This study's model could be used for practitioners and researchers to consider one's own influences and biases which may underlie one's own understanding and work with self-criticism, for instance a possible overemphasis on the personal critic versus the shared critic. Additionally, this model

teases out different aspects of the self-critic, such as its impact, how core and deep it is and its link to risk. It may be that psychologists might benefit from considering these areas more explicitly in their work.

All participants used CFT (Gilbert, 2009) and ACT (Harris, 2006) techniques to work with self-criticism. It may be that services and doctoral training courses could benefit from explicitly providing training about self-criticism and corresponding alternative models of mental health such as transdiagnostic approaches and therapy models.

4.5.Limitations

There are several considerations needed when interpreting this study's findings. Participants were recruited via an opportunity sample during the COVID-19 pandemic. It is possible that participants already with a personal or clinical interest in self-criticism were attracted to the study, meaning practitioners who disagree with the commonality of self-criticism presented here may be under-represented. Additionally, though participants were recruited from a variety of settings, there may be client groups who are not represented in this study, for example adults with intellectual disabilities or neurodevelopmental conditions. This has implications for reduced generalisability of study findings. Though grounded theory attempts to generate an overarching synthesis of data and a wider societal understanding of self-criticism is put forward within the model, there could be additional considerations for these groups.

This model only considered clinical psychologists' work with self-criticism. Other psychological and healthcare professions may have different valuable insights regarding self-criticism which are not investigated here, such as arts-based-psychotherapy (Beaumont, 2015) and drama therapy (Johnson & Emunah, 2020). Future research could investigate how

self-criticism is understood and worked with by specific and combined modalities in order to provide more comprehensive guidance for clinical practice.

This study was also based in the UK, where other countries, cultures and sub-cultures may have varying understandings and techniques to understand and support self-criticism work. Future research could help to develop culturally sensitive and appropriate interventions.

4.6. Conclusions

This study aimed to investigate how clinical psychologists understand and work with self-criticism in practice. Using GTM, a novel theory was developed to begin to understand the complexity of how clinical psychologists' clinical and personal experiences shape the way they integrate ideas to understand and generate change when working with self-critical clients. The theoretical, research and clinical implications are discussed along with suggestions for future research.

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Kirstie Stanworth, BSc (Hons), MSc, PGCert

UNDERSTANDING SELF-CRITICISM FROM PERSONAL AND PROFESSIONAL PERSPECTIVES

SECTION C:

APPENDICES OF SUPPORTING MATERIAL

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

DECEMBER 2022 (March 2023)

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Part A – Appendices

Appendix A. Critical appraisal of eight qualitative studies reviewed using CASP (2018) framework.

	Study 1. Austin et al. (2021)	**Study 2**. Bayir & Lomas. (2016)	**Study 3**. Bell et al. (2021)	**Study 4**. Brennan et al. (2014)	**Study 5**. Frentz et al. (2020)	**Study 6**. Kannan & Levitt. (2017)	**Study 7.** Thew et al. (2017)	**Study 8.** Waite et al. (2015)
1. Clear statement of aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Design appropriate for aims?	Yes	Yes	Yes	Partially	Partially	Yes	Partially	Yes
4. Recruitment strategy appropriate to the aims?	Yes	Partially	Yes	Yes	Yes	Yes	Yes	Yes
5. Data collection addresses research issue?	Partially	Yes	Yes	Partially	Partially	Partially	Partially	Yes
6. Researcher and participants' relationship adequately considered?	No	Partially	Yes	No	Yes	Yes	No	Yes
7. Ethical issues considered?	Yes	No	Partially	Yes	No	No	Partially	Yes
8. Data analysis sufficiently rigorous?	Yes	No	Yes	No	Yes	Yes	Yes	Yes
9. Clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Partially
10. Valuable research conducted?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix B. Sample of developing themes, codes and illustrative quotes

[Removed from electronic copy]

Appendix C. Example of code generation and descriptive theme development

[Removed from electronic copy]

Part B - Appendices

Appendix D. Study recruitment adverts

Appendix E. Information sheet

Appendix F. Consent form

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Appendix I. Model summary and feedback questions sent to participants

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Appendix M. Open coding transcript early example excerpt

Appendix N. Examples of early diagrams for each participant

Appendix O. Diagram examples of model development, codes and categories

Appendix P. Participant feedback

Appendix Q. Ethics approval

Appendix R. End of study participant report

Appendix S. End of study notification letter to Salomons ethics committee

Appendix T. Author guideline notes for chosen journal

Appendix D. Study recruitment adverts

FACEBOOK:

Qualified Clinical Psychologists needed for research study on self-criticism

Many of the people that psychologists see may experience difficulties with self-criticism, however little is known about how psychologists understand and work with self-criticism in practice.

We hope that your participation can help us to understand more about this area and will be a helpful piece of work for practitioners and researchers.

We are asking for an hour of your time for a telephone, virtual or face to face interview. For more information please see the information sheet and consent form available at: [removed]

Please feel free to contact me via email if you would like to take part or if you have any questions at: [removed].

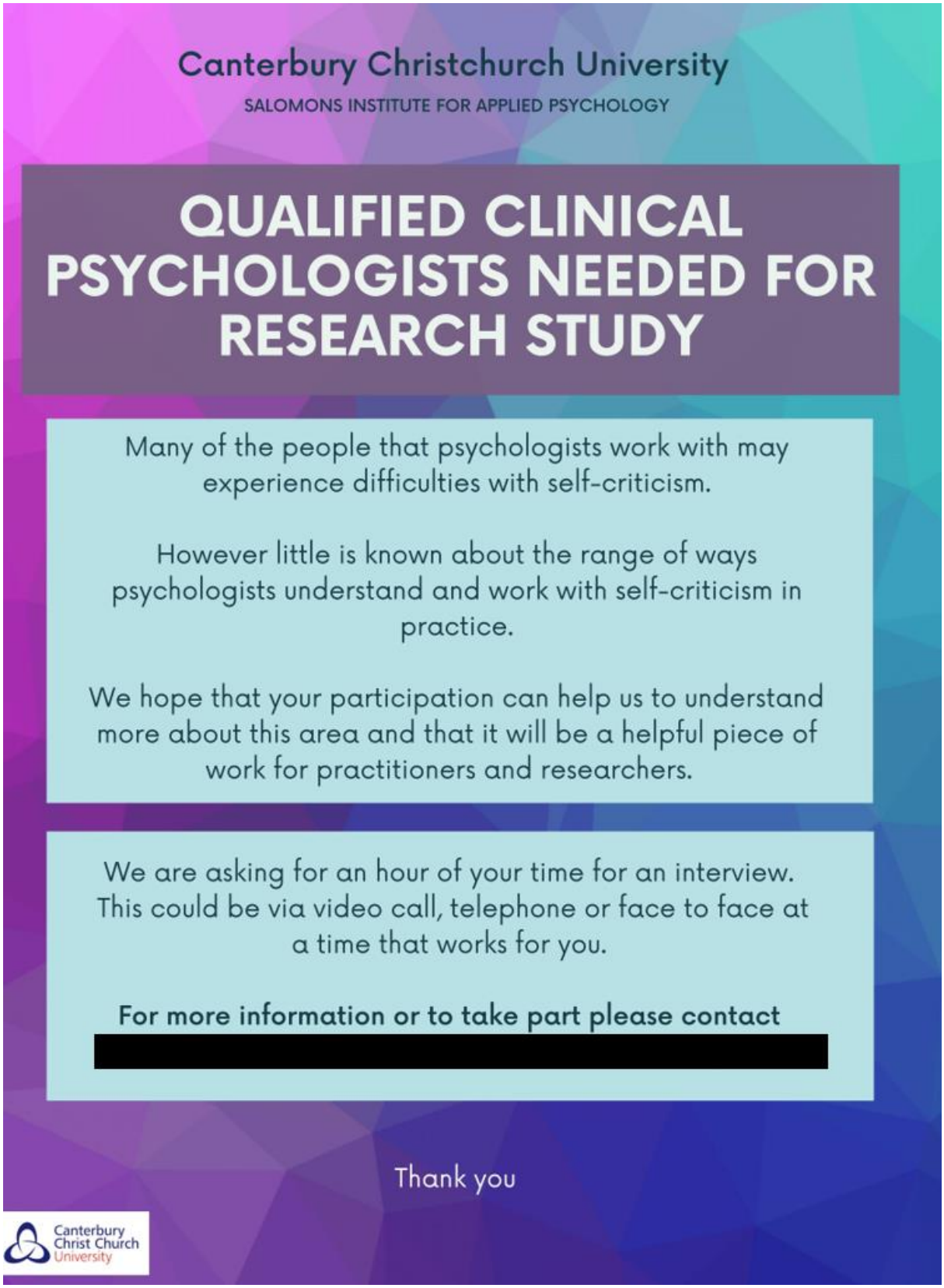
(picture below also attached)

TWITTER AND LINKEDIN:

Qualified Clinical Psychologists needed for trainee research on self-criticism

Asking for people willing to engage in a 1hr interview, aiming to create a helpful piece of work for clinicians, researchers and service users. If interested please contact me: [removed].

(picture below also attached)


Canterbury Christchurch University
SALOMONS INSTITUTE FOR APPLIED PSYCHOLOGY
QUALIFIED CLINICAL PSYCHOLOGISTS NEEDED FOR RESEARCH STUDY
Many of the people that psychologists work with may experience difficulties with self-criticism.
However little is known about the range of ways psychologists understand and work with self-criticism in practice.
We hope that your participation can help us to understand more about this area and that it will be a helpful piece of work for practitioners and researchers.
We are asking for an hour of your time for an interview. This could be via video call, telephone or face to face at a time that works for you.
For more information or to take part please contact
[redacted]
Thank you
Canterbury Christ Church University

Appendix E. Information sheet

Ethics reference: ETH2021-0031
Version number: 1
Participant Identification number for this study: TBC

INFORMATION SHEET

Research project

How do clinical psychologists understand and work with clients experiencing self-criticism in practice?

My name is Kirstie Stanworth and I am a trainee clinical psychologist at Salomon's Institute for Applied Psychology at Canterbury Christ Church University (CCCU). I would like to invite you to take part in a voluntary research study. Below is further information about the study and what it would involve. This research is supervised by [supervisors names anonymised].

What is the purpose of the study?
Self-criticism has been found to be present in clients experiencing a range of difficulties who may have been given one or more diagnoses. As such self-criticism may be frequently encountered by clinicians working in different settings. Though working with self-criticism may be incorporated into psychology training programmes, post training qualifications and supervision, little is known about how clinical psychologists understand and work with self-criticism in practice.

What will taking part involve?
If you agree to take part in the study, after completing the consent form I (Kirstie) would send a short survey to establish basic information via email, such as about your training, qualifications and work experience. This may take approximately ten minutes to complete. This information will be anonymised and included in the study write up.

You would then be invited via email to book an interview by online video calling software, telephone or face to face depending on your availability and preference. It is aimed that the interview would take approximately one hour.

In the interview I will ask about:

- Your clinical experiences of working with clients who have significant issues with self-criticism.
- How you understand and work with self-criticism in your practice.
- To talk (anonymously) about a recent client you have worked with for whom self-criticism was a major focus of the work.
- What influences your understanding and work with self-criticism in practice.

Sometimes a follow up interview may be needed, for example for clarification or exploring a specific aspect of working with self-criticism, I will contact you to ask whether you are able to attend a 30 minute follow up interview. This is your choice and you are welcome to indicate on the consent form whether you agree to this in advance.

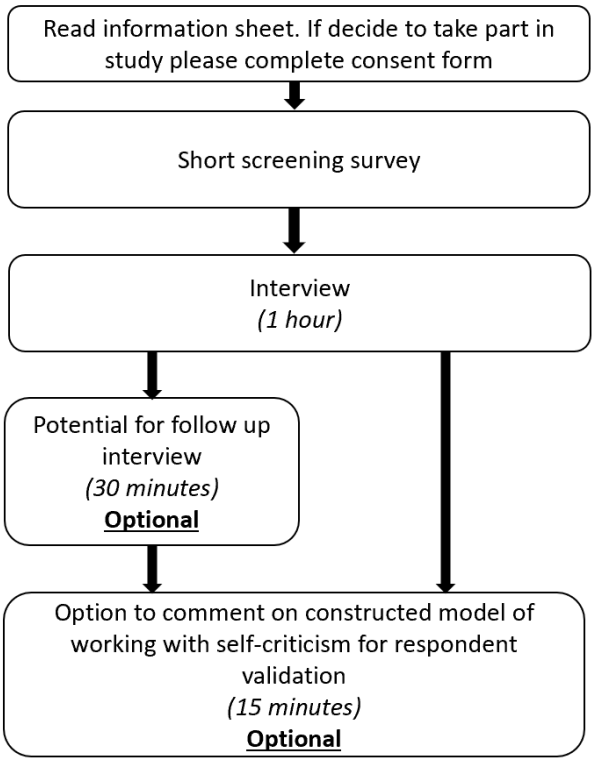
<u>All interviews will be audio-recorded</u> so that they can be transcribed, where recordings will then be erased. Your name and personal details would not be connected to the transcript and any names of people and places would be disguised to protect your anonymity. It is possible that some client details might be further disguised if there are idiosyncratic details that could identify them.

We are using the information from the interviews to construct a model of working with self-criticism in practice, using a grounded theory methodology. We would like to contact all participants with a short draft

summary of our findings with some feedback questions for the purposes of respondent validation. This also is optional but will be helpful for us to finalise the model.

The different aspects of the project participation are summarised in Figure 1 below.

Figure 1.
Flowchart of project participation.



To participate in this research you must:

- Be a qualified accredited Clinical Psychologist who has 3 years or more clinical experience post-qualification.
- Have worked in adult mental health with clients who are 18+, at least some of whom experienced significant self-criticism such that you worked on this with them within the past 12 months.

Are there any risks to taking part?
We do not anticipate any particular risks to you in taking part in this project. If you anticipate finding participation difficult or distressing (for example touching on very distressing clinical experience) then we would advise you to discuss the project with someone supportive before deciding whether to take part.

Are there any benefits to taking part?
There would be no direct benefit to you, other than contributing to the evidence base. The experiences people share with us could help to support clinical psychologists in their clinical work or continuing professional development. If you have travelled to take part in this research, we are able to pay your travel costs of up to £10. We aim for this to be a helpful piece of work for practitioners and researchers and you will also be offered the option to receive a summary of the study findings.

Confidentiality
Your interview data will be transcribed and anonymised with any personal information disguised. Anonymised short extracts and quotes of interview data may be used for publication and write up of this project. The contents of the interview will remain confidential unless you tell me something that gives reason to be concerned about your safety or the safety of others. In this case I may need to discuss the issue with the research supervisors, but would normally try to discuss it first with yourself.

In the rare event that a serious concern is raised regarding unprofessional practice, this will be raised in the first instance with [supervisors names anonymised] with the next point of escalation as the Salomon's Institute Research Director [name anonymised] for guidance.

Data will be stored securely within CCCU online secure databases in accordance with GDPR and the University's own data protection requirements. Data will be stored on an encrypted and password protected memory stick prior to transcription and anonymisation. The full anonymised transcripts of the interviews will only be accessed by myself, [supervisors names anonymised]. Your name and contact details will be stored separately to the interview transcript in a password protected document. After completion of the study, the anonymous transcripts will be stored on an encrypted memory stick in a locked filing cabinet for 10 years after which time they will be destroyed by CCCU. Please refer to our Research Privacy Notice for how we will use and store your data https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx

Feedback and Dissemination of results
You have the option of requesting a brief summary of the findings of the study and may request a copy of any research paper that is published. We plan to submit a paper for publication in approximately June 2023 and publication may take several months to be peer reviewed.

Who has reviewed the study?
The Salomon's Ethics Panel at Canterbury Christ Church University has reviewed and approved the project.

Deciding whether to participate or withdraw
If you have any questions or concerns about the nature, procedures or requirements of the study please discuss these with Kirstie (contact information below). Should you decide that you are going to participate in the study, you will be free to withdraw from the study at any time within two weeks after the date of your interview without having to give a reason.

Any questions?
Please contact Kirstie Stanworth, Trainee Clinical Psychologist.
Email: [removed]

If you are unhappy with any aspect of the research project: please talk to Kirstie in the first instance. If you remain unsatisfied, you may contact [name removed], lead project supervisor, via email [email removed], or [name removed], Research Director: [email removed]

Appendix F. Consent form

Ethics reference: ETH2021-0031
Version number: 1
Participant Identification number for this study:

CONSENT FORM

Title of Project: How do clinical psychologists understand and work with clients experiencing self-criticism in practice?

Name of Researcher: [NAME REMOVED}

Please initial all boxes that are applicable:

	Initials
I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I agree to my interview(s) being audio recorded.	
I agree to the possibility of being contacted for a follow up interview (OPTIONAL).	
I agree to being contacted with a brief description of the model constructed from the interviews and being asked to comment on this (OPTIONAL).	
I understand that my participation is voluntary, unpaid and that I am free to withdraw my data at any time without giving a reason, within two weeks of the date of my interview(s) taking place.	
I understand that data collected during the study may be looked at in an anonymised form by the lead supervisor [Information anonymised]. I give permission for these individuals to have access to my anonymised data.	
I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings.	
I agree for my anonymous data to be used in further research studies along similar lines to this one (OPTIONAL).	
I agree to being contacted via email for the purposes of this study.	
I agree to take part in the above study.	

Name of Participant:	Date:	Signature:

Name of person taking consent ***(if different from researcher)***	Date:	Signature:
Researcher:	Date:	Signature:

Copies: 1 for participant

1 for researcher

If you would like a copy of the study findings sent to you when the project is complete, please initial the box and write your email address below.

	Initials
I would like to be emailed a summary of the project findings when the project is complete.	
I would like to be emailed the published research paper when this is completed. I understand this may take several years from my participation to be sent.	

Email address: _____

Appendix G. Demographic survey

Initial project survey

Title of Project: How do clinical psychologists understand and work with clients experiencing self-criticism in practice?

Unique Identifier number:

About you

Gender (Please write what best describes your gender identity e.g. male, female, transgender, unknown, non-binary, questioning etc. If you are unsure or uncomfortable, please leave it blank or talk to the researcher)	
Ethnicity (please write what you feel best describes your ethnic background e.g. you may wish to write: Black-Nigerian and British, White – French, Mixed-American and Malaysian, White- British. If you are unsure or uncomfortable, please leave it blank or talk to the researcher)	
Sexual orientation (please write what you feel best describes your sexual orientation e.g. asexual, heterosexual, queer, gay, lesbian, bisexual, questioning etc. If you are unsure or uncomfortable please leave it blank or talk to the researcher)	
Religion	
Age	
Country you are based in (if outside the UK)	

About your training and qualifications

Which country did you train in?	
Which psychological models did you train in? (e.g. psychodynamic, CBT, systemic practice)	
How many years have you been qualified as a Clinical Psychologist?	
What client groups have you worked with?	

Do you have any qualifications specific to psychological models or therapies either during qualification or post qualification? (e.g. BABCP level 3 registration for CBT, ACAT accreditation for CAT, AFT family therapy training level 2 accreditation)	During qualification: Post qualification:

About your current clinical practice

What are some of the main difficulties or diagnoses for which clients come to you?	
How would you describe your service? (e.g. IAPT primary care, secondary care general mental health service, tertiary care, specialist health service, specialist perinatal service etc).	
What client groups do you work with? (e.g. working age adults, mild learning disabilities)	
Which models do you regularly use in your clinical practice? (e.g. CBT, DBT, integrative with CAT and ACT).	
Why did you choose these psychological models in your clinical practice? (Please highlight any that apply)	▪ Evidence based for client group ▪ Service offered this training programme ▪ Service likes me to use only this model/ these models ▪ Personal preference/ interest ▪ Supervisor preference/interest ▪ No other therapy training programmes available ▪ Other (please specify):

Availability

What is your general availability for an interview?	

Appendix H. Debrief sheet

Version number: 1

DEBRIEF SHEET

Project title: How do clinical psychologists understand and work with clients experiencing self-criticism in practice?

Thank you for taking part in my study.

The aim of the study was as advertised - to understand how psychologists understand and work with self-criticism in practice.

Please take some time to think about whether you have any questions. If you later realise you have questions, please feel free to email me on [email removed]

It can be helpful to take some time to think about how you are feeling and whether you feel you would like any support. Some general support organisations are listed below:

- Support for Mental Health Professionals with lived experience: https://www.in2gr8mentalhealth.com/
- Samaritans: 24/7 phone or webchat support. Call 116 123 https://www.samaritans.org/how-we-can-help/contact-samaritan/chat-online/
- Campaign against living miserably: For those who identify as male (5pm-midnight daily) 0800 58 58 58 or you can use their webchat service https://www.thecalmzone.net/
- If you are concerned about your mental health, please contact your GP.

If you have been unhappy with any aspect of the research, please do let me know. Alternatively you are welcome to contact [supervisors details removed]

Thank you

Appendix I. Model summary and feedback questions sent to participants

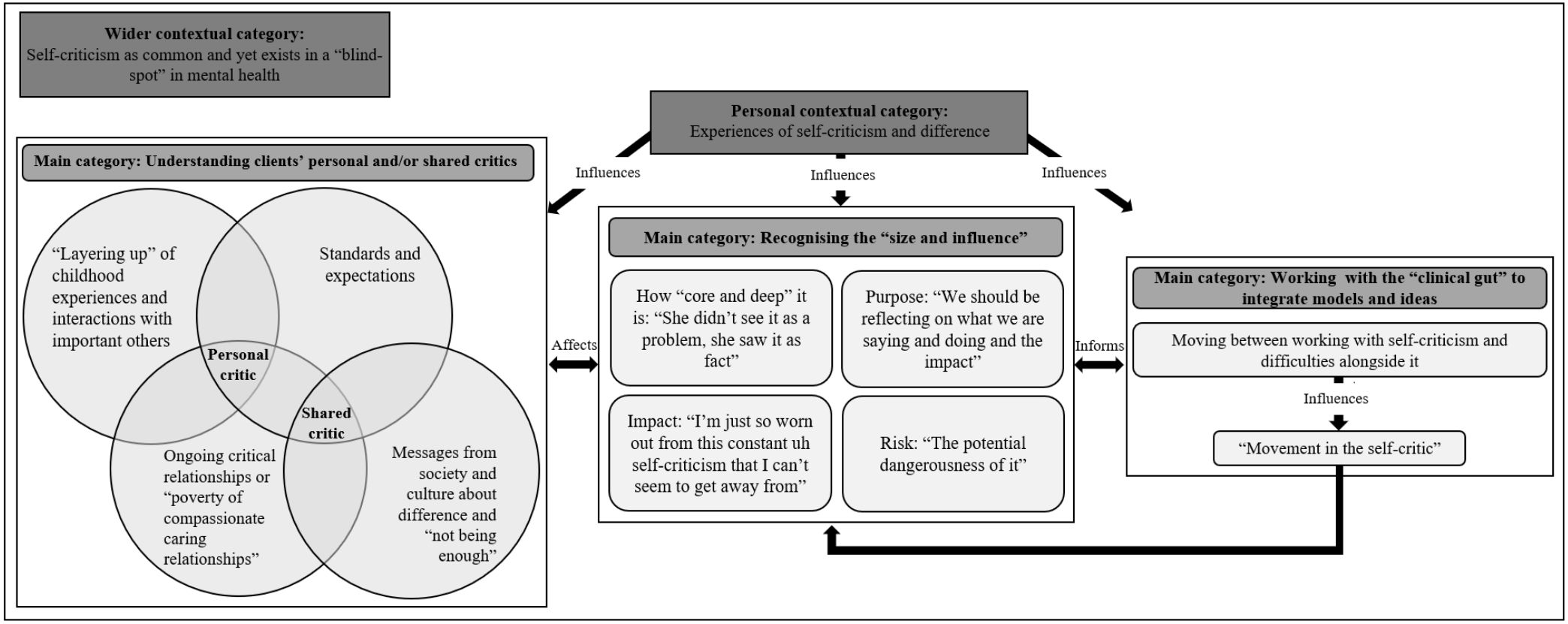
Email to participants: [Removed from electronic copy]

Model summary

Categories	Summary
Contextual category: Self-criticism as common and yet exists in a "blind-spot" in mental health	Self-criticism was felt to be a common human experience seen both generally and in clients, however despite this, many participants revealed that they had not thought about self-criticism in detail before the interviews. Self-criticism was felt to exist in a blind-spot for psychologists, clinical training and the medical model.
Contextual category: Experiences of self-criticism and difference	Participants described how their personal experiences of self-criticism and difference appeared to affect how they understand self-criticism and how they work with it. There was also a link between direct personal or clinical experience of difference or being in minoritized groups and how self-criticism was understood within either an individual or family context compared to a wider social context.
Main category: Understanding our personal and/or shared critics Subcategories: • "Layering up" of childhood experiences and interactions with important others • Ongoing critical relationships or "poverty of compassionate caring relationships" • Standards and expectations • Messages from society and culture about difference and "not being enough"	The diagram shows that these areas heavily overlapped in discussions, linking to an idea of areas which might contribute to a "personal critic" and areas which contribute to a "shared critic". The majority of participants felt that problematic self-criticism stemmed from early childhood experiences, attachment figures or trauma, usually with parents and caregivers. Several participants extended this to a child's wider social relationships, including experiences of bullying by peers and relationships with teachers. Participants described situations where clients had ongoing relationships with critical caregivers or were in relationships with critical others, feeding into their self-critic Participants linked self-criticism to standards and expectations of oneself and/or from others rooted in a family, school and work contexts (e.g. police, military). Some participants understood self-criticism as being linked to often intersecting societal messages about: norms; dyslexia; open relationships; gender; gender diverse people and transphobia; queer identities and internalised homophobia; immigration experiences; physical health conditions and disabilities; discrimination and deprivation; and social media.
Main category: The "size and influence" Subcategories:	

• How "core and deep" it is: "She didn't see it as a problem, she saw it as fact" • Purpose: "We should be reflecting on what we are saying and doing and the impact". • Impact: "I'm just so worn out from this constant uh self-criticism that I can't seem to get away from" • Risk: "The potential dangerousness of it"	Some participants talked about individuals who had experienced years of self-criticism which felt entrenched, usually being unfair, unquestioned, inflexible and often unrealistic. Thoughts of changing or questioning the self-critic were immensely difficult for them. All participants thought about the purpose of self-criticism for the people they discussed, where everyone talked about it serving a protective function, beginning discussing self-criticism as a problem or difficulty, however several participants described thinking about self-criticism as a continuum where it serves an important social function and can be important in certain situations, where the absence of self-criticism could be troubling. Self-criticism was understood to have a huge emotional impact on individuals, impacting feelings of shame, low mood, fear and anxiety and generally amplifying other emotional It impacted how people viewed the world, their relationships with themselves, others and their therapist, as well as their life, work and wellbeing. Linked to the impact above, participants described self-criticism as underlying or linked to peoples: suicidal thinking, self-harm, harm to others, risky sex, dangerous eating behaviours and substance use.
Main category: Working with the "clinical gut" to integrate models and ideas Subcategories: • Moving between working with self-criticism and difficulties alongside it • Movement in the self-critic	This ability to use one's gut to integrate ideas led to a common thread throughout all participants, which heavily influenced how participants worked with self-criticism. Participants described working in a client centred way, having one or more "go-to" formulations or approaches, integrating models and ideas, flexibly changing approaches as needed. Formulations considered whether the self-criticism was underlying or contributing to difficulties. This meant sometimes using different approaches for different aspects of the persons presentation e.g. EMDR for trauma processing and CFT for self-criticism. Several participants also described talking about working with risk alongside self-criticism work. For self-criticism work itself, participants predominantly used CFT and ACT ideas alongside: collaborative formulation building; psychoeducation; awareness building and naming; holding the critic lightly, developing self-compassion and experiential techniques. Participants also described an uncertainty in the work whereby it was not known if working on other difficulties would generate useful sufficient movement the self-critic or whether it would remain. Self-criticism was thought of as something that might reduce but never fully disappear, where one's relationship to it, ability to manage it and development of self-compassion were key indicators of change.

Model diagram



Feedback questions

- Do you feel that the model has captured working with self-criticism for you?

- Do you feel that the model is missing anything?

- What do you think the model explains well?

- Any other comments?

Appendix J. Interview schedule

General questions

1. What do you consider to be self-criticism?
2. How do you recognise this in a clients presentation
    a. How do you notice if it is the main or target difficulty for a client?
3. What have you noticed are the impacts of self-criticism for clients?
4. How do you understand, conceptualise and work with clients who are self-critical in practice?
    a. Do you use one model or integrate? If so, how?
    b. Do you think X model adequately explains self-criticism for you?
        i. Is it missing anything? What are it's strengths?
        ii. What do you think it adds to the understanding of self-criticism?]
    c. What do you think the differences between problematic and non problematic self-criticism might be?

Client specific questions

Think of a specific client you have worked with for whom self-criticism was a major difficulty for them and a major focus of therapy.

Clinical formulation questions

- How did you recognise/assess/identify that self-criticism was the main difficulty for them?
- How did you conceptualise self-criticism in your formulation?
    - Which model/model did you choose to work with them?
    - What affected your decision to choose that model over another model?
    - Did you integrate models and if so, how?
    - Did you need to switch models or techniques to suit the client at any point?
- What do you think went well/ didn't go well working with self-criticism with this client?
- How did you focus on strengths/ strengths based approaches, if at all?
- How did you manage the intense feelings that self-criticism might bring?

Working with the client/ Client experience questions

- Did the client agree that self-criticism was an important problem for them?
- How did you support them with recognising this, if at all?
    - How did you communicate that self-criticism might be a central problem (if they weren't already aware)?
    - Was there anything you noticed you did to improve motivation/increase understanding to work on this?
- How did they conceptualise/ describe their self-criticism? (incl, what language did they/ you use? E.g. bully, hard on myself)
    - Did this differ from how you viewed self-criticism?
    - How did you conceptualise working with self-criticism together?
    - Did you share your formulation? If so, how much did you share?
- Did they want to work on their self-criticism?
    - How did you decide to work on this together?
- Were there any barriers to working with self-criticism?
- Were there any factors which made it easier to work with self-criticism?

- What do you think they found helpful in your work about the intervention for self-criticism?
- What do you think they found unhelpful about your intervention for self-criticism?

Other clients

- Are there any other clients whereby the above approach hasn't worked?
    - What worked instead with those clients?
    - What are your thoughts about why this didn't work for this client?

Prompt – could ask about another client case example.

Practice specific questions

5. What do you think has informed your practice when working with self-criticism?
   a. Prompts:
      i. Has your way of thinking about and working with self-criticism changed since qualifying with experience? If so, how? Has it changed over time? What do you think may have influenced that?
      ii. If you are comfortable to do so, can you tell me about a time you have noticed your own self critical processes and how this influenced your work with clients who are self critical? What about your own experience of self-criticism? Tell me about a time (if you are comfortable to do so) you have noticed your own self-criticism and how this influenced your work with your clients?
      iii. How has supervision, if at all, influenced your understanding, conceptualisation and ways in which to work with self-criticism?
      iv. Any areas of your background or social GRACES influenced this?
      v. Tell me about a time you have noticed your own self criticism and how this influenced your work with your clients?

Anything else

6. Is there anything else you can think of that we haven't discussed today that you feel might be relevant to how self-criticism is understood and worked with in practice for you or in general?

Appendix K. Abridged research diary

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Appendix L. Theoretical memoing

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Appendix M. Open coding transcript early example excerpt

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Appendix N. Examples of early diagrams for each participant

(Used to consider how each person was conceptualising the topic and to compare between people)

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Appendix O. Diagram examples of model development, codes and categories

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Appendix P. Participant feedback

(Consent was gained via email to include a few excerpts of the anonymised feedback in the appendix of this write up for the persons below).

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Appendix Q. Ethics approval

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Appendix R. End of study participant report

Study title: How do psychologists understand and work with people experiencing self-criticism in practice?

Dear participant,

Thank you for taking part in the study. The study initial findings were recently emailed to all participants as requested for review. We had a great response and your feedback was incorporated into the final model (diagram copied at end).

This study used qualitative grounded theory methodology to generate a theory of how clinical psychologists understood and work with clients experiencing self-criticism in practice.

Brief overall model summary:

Self-criticism was understood to be common in mental health yet exists in a "blind-spot". Participants' personal and clinical experiences of self-criticism and of difference affected how they understood how self-criticism to have "personal" or "shared" influences. This affected how participants recognised the size and influence of clients' self-criticism, how: core and deep it was; the purpose; impact; and link to clients' risk. Participants used their intuitive "clinical gut" to work with self-criticism to integrate models and ideas, moving between working on self-criticism and difficulties alongside it, affecting "movement in the self-critic". This fed back and in turn influenced the size and influence of clients' self-criticism.

Summary of model:

The model proposes a wider contextual category stating that though psychologists' viewed self-criticism as common, self-criticism was suggested to exist in a blind-spot in mental health. This was suggested to be due to psychologists working within a diagnostic medical model of healthcare, where language is organised around "disorders" such as OCD. This way of thinking was thought to miss important underlying difficulties such as self-criticism. It was also suggested that the difficult route to clinical psychology training may self-select people with high standards and expectations of oneself, perhaps impacting how the profession recognises and understands self-criticism within mental health.

Psychologists personal/clinical experiences of self-criticism or working with difference influenced their understanding of self-criticism. Two overlapping categories were identified, where self-criticism was viewed as "personal" (being related to early childhood experiences) or "shared" (related to societal messages). For example, people with direct personal experiences of being in a minoritized group, viewed self-criticism as more linked to societal messages than childhood experiences.

How people understood self-criticism affected how they recognised the size and influence of it. This was split into four categories: how core and deep it is; purpose; impact; and risk. Some people's self-criticism was viewed as core and deep whereas for others, it might have been activated and problematic following a life event. Everyone saw self-criticism as having a purpose, from having an important social function for everyone, to representing a survival strategy for coping with adversity. Self-criticism was viewed as having significant possible impacts for clients, on their life, work and wellbeing, from being entwined in their feelings of

shame, depression, anxiety and fear, to magnifying emotions. Clients were found to view the world and therapy work through a veil of self-criticism, amplifying negative messages and dismissing positive messages, where no possible other view of the self could easily emerge. Clients' self-criticism could affect how they engaged in therapy and the therapeutic relationship. Self-criticism was also found to link to clients' suicidal ideation, self-harming behaviours, risky sexual behaviours, dangerous eating behaviours and substance use.

The recognition of the size and impact of self-criticism affected how psychologists worked with it. Psychologists described working with their "clinical gut" to integrate models and ideas, working in an intuitive, client centred way developed over time with experience. Psychologists noticed a process of moving between working with clients' self-criticism and their difficulties alongside it, which might involve using one or more psychological therapy models. For example, this might include applying eye movement desensitisation and reprocessing therapy (EMDR) to support someone with their traumatic experiences and using compassion focused therapy (CFT) for their self-critical experiences.

Psychologists would use their understanding of the person to notice any movement in their self-critic, which in turn influenced the "size and influence" of the self-criticism.

Implications

The implications of these findings could include:

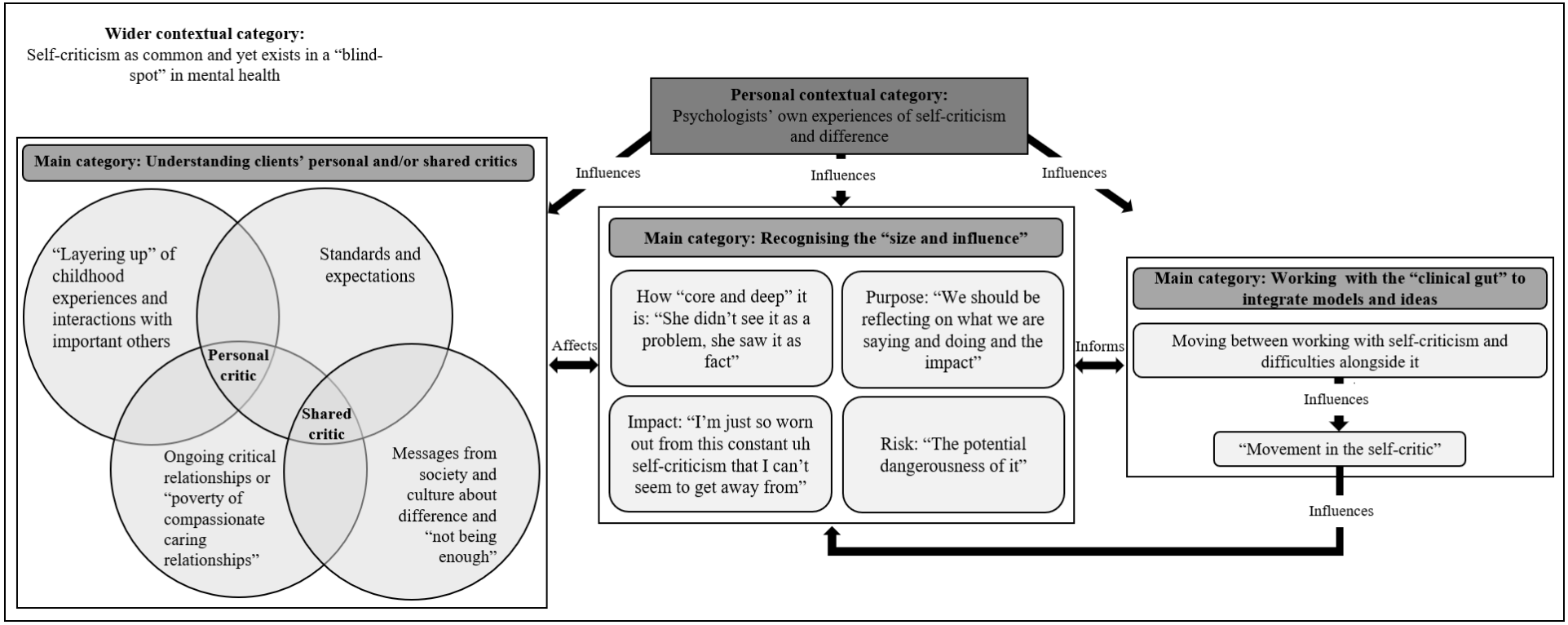
- The importance of recognising societal issues in understandings of mental health and wellbeing. It is possible that cultural, societal and structural causes and impacts of self-criticism may be under recognised or addressed in current theoretical models. This has implications for how self-criticism is understood and worked with in practice.
- The importance of valuing and increasing access to people with diverse experiences within the profession and within services to address such issues
- Research paradigms could consider how to capture valuable insights from clinical practice where work is conducted in client centred, integrative ways. This is because these might not naturally sit within current ways of researching therapies e.g. randomised controlled trials
- Self-criticism could impact a person's risk. It could therefore be a key factor to consider in risk management plans. It may be that risk management plans could benefit from being linked to a person's formulation.
- Services and training programmes could benefit from providing explicit training focusing on understanding and working with self-criticism. Since all participants used compassion focused therapy to work with self-criticism, this may be an important model to promote.

Thank you very much for taking the time to take part in the study, it is really appreciated.

Best wishes,

Kirstie Stanworth

Trainee Clinical Psychologist, Salomons Canterbury Christ Church University


Wider contextual category:
Self-criticism as common and yet exists in a "blind-spot" in mental health
Personal contextual category:
Psychologists' own experiences of self-criticism and difference
Influences
Influences
Influences
Main category: Understanding clients' personal and/or shared critics
"Layering up" of childhood experiences and interactions with important others
Standards and expectations
Personal critic
Shared critic
Ongoing critical relationships or "poverty of compassionate caring relationships"
Messages from society and culture about difference and "not being enough"
Affects
Main category: Recognising the "size and influence"
How "core and deep" it is: "She didn't see it as a problem, she saw it as fact"
Purpose: "We should be reflecting on what we are saying and doing and the impact"
Impact: "I'm just so worn out from this constant uh self-criticism that I can't seem to get away from"
Risk: "The potential dangerousness of it"
Informs
Main category: Working with the "clinical gut" to integrate models and ideas
Moving between working with self-criticism and difficulties alongside it
Influences
"Movement in the self-critic"
Influences

Appendix S. End of study notification letter to Salomons ethics committee

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Appendix T. Author guideline notes for chosen journal.

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