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Employing a Case Study in Building an Assimilation Theory Account of Generalized Anxiety Disorder and Its Treatment with Cognitive-Behavioral Therapy

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ABSTRACT

This theory-building case study aimed to elaborate an account of anxiety and its treatment within an assimilation model of therapeutic change (e.g., Stiles, 2002). A team consisting of the senior author and two other co-investigators independently reviewed the case of Robert, a 52 year-old man who was successfully treated for generalized anxiety disorder (GAD) in a clinical trial of cognitive behavior therapy (CBT). The team observed the expression of Robert's major *voices*—the assimilation model's name for the individual parts of a client's personality—in the audio record of the client's in-session dialogue. Prominent among these was a *critic voice*, described by co-investigators as harsh and derisive toward other aspects of the self. Our work led us to infer that, although the critic voice seemed closely associated with the anxiety that characterized Robert's GAD, it did not produce that anxiety directly through its attacks on his other voices. Rather, the *critic* voice induced vulnerability to specific, anxiety-arousing external circumstances by derogating Robert's coping skills or exaggerating the threat of specific external circumstances. Robert's anxiety then arose when he encountered those circumstances.

Key words: assimilation model; case study; generalized anxiety disorder; clinical case studies; case studies

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What distinguishes anxiety disorders from other disorders is, of course, the centrality of anxiety. Thus, an adequate account of anxiety disorders and their treatment must pay particular attention to explaining what anxiety is, how it is produced, and how it can be overcome. This theory-building case study aimed to elaborate an account of anxiety and its treatment within the assimilation model (Stiles, 2002, 2011; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990) using the case of Robert, a 52-year-old man who was successfully treated for generalized anxiety disorder (GAD) in a large clinical trial of the efficacy of various components of cognitive-behavioral therapy (CBT), such as applied relaxation training, systematic desensitization, and cognitive restructuring (Borkovec et al., 2002).

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FORMULATING ANXIETY WITHIN THE ASSIMILATION MODEL

The assimilation model is a theory of psychotherapeutic change that seeks to describe the process by which clients in therapy of any type work through the problematic experiences that brought them into treatment (Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Stiles, 2002, 2011; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990). The model has been developed mainly through intensive qualitative analyses of individual cases of therapy. Early studies involved treatments for depression, but subsequent work has extended the model to conceptualize how clients work through other sorts of problems, including traumatic events such as surviving torture or childhood sexual abuse (Varvin & Stiles, 1999; Salvi, 2005); borderline or dissociative disorders (Osatuke & Stiles, 2006); chronic and medically unexplained somatic symptoms (Reid & Osatuke, 2006); acculturation stress (Henry, Stiles, & Biran, 2005); social phobia (Gray et al., 2004); and complications associated with dissociative identity disorder (Humphreys et al., 2005).

The assimilation model proposes that experiences leave traces that can be reactivated. These traces are agentic in people; that is, they respond when they are addressed and are manifest in a person's speech and actions. The model describes these traces of experience metaphorically as *voices*. For example, the constellation of traces having to do with your mother comprises the voice of your mother in you, and it may emerge and speak when circumstances address it. The self can be described as a community of voices.

The theory proposes that affect is what happens when voices encounter each other or some new event (Stiles, Ostauke, Glick, & Mackay, 2004). If these are compatible, the affect is positive or neutral; if they are incompatible, the affect is negative, with the valence reflecting the degree of incompatibility. Thus, the model envisions a continuum of relations between voices, ranging from pain and avoidance to smooth (even seamless) mutual access. In particular, *problematic experiences*, such as traumas and destructive primary relationships, leave traces that cause emotional pain and avoidance when they are reactivated. To formulate the phenomenon of anxiety within the model, then, the important question to answer is what sort of contact between voices distinctively produces anxious affect. What type of internal dialogue leads specifically to worrying, fear, or panic?

We began with earlier observations (Gray et al., 2004) that when clients with social phobia experienced anxiety, it appeared that a *critic* voice within their internal communities was speaking in a shaming way. Insofar as this self-shaming led clients to avoid potentially threatening interpersonal contact, the *critic* voice seemed to effect a crude means of self-protection. That is, the repetitive, nagging *critic* appeared to temporarily distract clients from attending to painful thoughts and feelings associated with feared situations. In a larger sense, however, the intervention by the *critic* voice was counterproductive, insofar as derogation of other parts of the person by the *critic* voice appeared to produce anxiety instead of preventing it. That is, although these expressions by the *critic* may have developed to keep the client's internal community from being overwhelmed, they ultimately seemed to exacerbate client distress. Aspects of *critic* voice dynamics seemed likely to generalize beyond social phobia, and we hypothesized that GAD, which is principally characterized by chronic, pervasive worry—or free

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floating anxiety, as it is called in DSM-IV (2000) diagnostic criteria—could be conceptualized as a contentious internal dialogue between a *critic* voice and other, meeker voices in the client's community. As we explain later, our observations in the present project led to some elaborations and modifications of this account.

ASSIMILATION OF PROBLEMATIC EXPERIENCES IN PSYCHOTHERAPY

The theory suggests that therapy can move relations between voices along the continuum from pain and avoidance to smooth and comfortable mutual access. It proposes that problematic voices can be integrated into the community following a developmental progression summarized in the Assimilation of Problematic Experiences Sequence (APES; Stiles, 2002; Stiles et al., 1992; see Table 1). The sequence ranges from the problematic voice being warded off or actively avoided to being integrated into the community as a resource. In between, the problem is recognized, then formulated, then understood, and then overcome.

Assimilation proceeds by building semiotic *meaning bridges* that give access to experiences (Stiles, 2011). For example, the word *dog* gives access to experiences of dogs. A self-narrative gives access to significant life events. If a client's self-narrative excludes some experiences, he or she will not have smooth access to them (Gonçalves et al., 2011; Osatuke et al., 2004; Stiles, 2011). In therapy, an accurate understanding or interpretation links significant experiences in a person's life in a coherent way. The meaning bridge gives mutual access between conflicting parts of the self. After a problematic voice is assimilated into the larger community, it ceases to be painful and alien. Instead, it becomes a resource, aiding the client in navigating situations that were previously feared or overwhelming. Following Gray et al. (2004), then, we hypothesized that a close examination of successful treatment for GAD would show development of meaning bridges with the client's *critic* voices.

CONNECTIONS TO RELATED GAD RESEARCH

Our thinking about anxiety disorders within assimilation theory drew on several other conceptual models of GAD. Among the most commonly discussed factors in the development of anxiety disorders are problems with emotional regulation and cognitive processing biases. Emotional regulation refers to a person's capacity to identify intense affect and find acceptable ways of calming him/herself. People with anxiety disorders often struggle with emotional regulation skills, finding it difficult to soothe themselves and work through negative feelings once these have been triggered.

The cognitive processing biases associated with anxiety involve illogical and catastrophic appraisals of neutral events (Beck & Emery, 1985; Wells, 1997). Typically, this involves fixating on the worst outcome of an ambiguous situation and assuming that a strongly negative resolution to a situation is the most likely among many possible alternatives. While they involve different mechanisms, problems with emotional regulation and cognitive processing error have the same net effect on anxiety sufferers—they compromise the person's ability to cope with or deescalate anxious arousal, increasing vulnerability to its debilitating effects.

In a theory paper, Borkovec, Shadick, & Hopkins (1991) asserted that GAD sufferers are fearful of the sensations and mental imagery associated with negative affect, and they employ self-doubt and ruminative worry as a (largely non-conscious) strategy for distracting themselves from these feelings and associations connected to these dreaded events.

In a follow up, Borkovec & Roemer (1995) surveyed clients with GAD, asking them to self-report the functions that worry/anxiety served in their lives. Interestingly, among the six major themes the authors identified, the response that was most common was distraction from more emotional topics. These authors took this to mean that anxiety experienced in GAD is essentially a defensive strategy. It allowed clients to escape into repetitive, albeit unpleasant, intellectualizing and avoid attending to more acutely painful emotional experience. In many ways, this is similar to defensive functions served by behavioral avoidance (such as is the case in clients with phobias) and somatization, where painful emotional experience—unable to be expressed verbally/conceptually—instead manifested itself in the form of physical complaints.

Conceptual models of GAD similar to this one have also been proposed elsewhere, most notably by Wells & Papageorgiou (1995); Dugas, Freeston, Ladouceur, Rheame, Provencher & Boisvert (1998); and by psychodynamic theorists Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shapell (1996). As is also the case with the Borkovec et al. (1991) model, these conceptual models of GAD assert that anxiety is a maladaptive defense, a means of shielding clients from more painful emotional experiences and at the same time, perpetuating avoidance of their resolution.

THEORY-BUILDING CASE STUDIES

The present case study was grounded in the logic of theory-building case research (Stiles, 2009). A central tenet of theory-building case study research is that observations about rich material from individual cases—both the commonalities and differences—can be combined to inform and support theories about complex underlying psychological phenomena.

The logic of theory-building case studies can be contrasted with statistical hypothesis-testing (Stiles, 2009). In statistical hypothesis-testing research, a hypothesis is deduced from the theory and compared with observations. A hypothesis is a statement. If observations from many cases match the statement—more than would be expected by chance—then there is some increase confidence in that statement and a small increment of confidence in the theory.

In contrast, case studies bring observations to bear on many different theory statements. Each statement may be tested by only one or a few observations. Even if the observations match the theory, then, the increased confidence in any one specific statement may be small, so isolated generalizations are not justified. Nevertheless, confidence in the theory as a whole may be increased significantly because many theoretically-relevant observations are made (Campbell, 1979; Stiles, 2009). To put it another way, observations on many aspects of one case are as valuable as observations on one aspect of many cases. Of course, no one study is definitive, whether it is a hypothesis-testing study or a case study. Using either strategy, the increment in confidence attributable to any one study is small; observations of many cases, aggregated over

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time, are necessary to build a theory.

Case studies also make use of the logical operation (like deduction and induction) of *abduction* (Peirce, 1867/1960). Through abduction, an existing theory can be modified incrementally to incorporate new observations and discoveries. Abductions may sometimes logically require modification to other parts of a theory. Thus, abduction provides a way for theory to expand into domains it has not yet covered. Theories can be modified to account for new observations within a new case, provided that the modified version continues to account for phenomena covered in the past. Note that abduction is strongly constrained; any new bit of theory has to remain consistent with earlier observations and with the rest of the theory. Of course, abductions are always tentative and need to be confirmed in further cases.

STUDY PURPOSE AND DESIGN

This case study aimed to elaborate an assimilation theory account of the problems faced by clients with GAD through observations on an individual therapy case. Informed by previous observations regarding *critic* voices, we set out to identify the configuration of voices associated with this client's experience of anxiety and how contact between these voices seemed to specifically produce worried, dysphoric affect. We summarize highlights of our abductions later, at the beginning of our Results section.

This case was selected from the data archives of a large clinical trial at Penn State University (Borkovec et al., 2002). The trial was designed to identify the efficacy of various components of cognitive behavioral therapy (e.g., applied relaxation training, systematic desensitization, or cognitive restructuring) useful for reducing the anxiety of clients with GAD. CBT is a widely-accepted, empirically-supported treatment for GAD (see Borkovec et al., 2002; Borkovec & Costello, 1993; Labdouceur et al., 2000). We focused on verbatim passages of the client's speech from therapy sessions. Our observations served as a basis for some tentative refinements to the assimilation model to help it account for phenomena—like excessive worry and harsh self-criticism—frequently observed in clients with GAD.

Method

Participants

Client. This case was drawn from the archives of the GAD III project (see Borkovec et al., 2002), a large clinical trial examining the efficacy of cognitive therapy, applied relaxation/desensitization training, and cognitive-behavioral therapy for treating generalized anxiety disorder. The client, referred to by the pseudonym "Robert," was a 52-year-old male with a Master's degree. He was one of four such clients studied by our group (Gray, 2010). He was considered to be a good-outcome case, although as shown in Table 2, he showed considerably more change on assessor-completed measures (the Hamilton Anxiety Rating Scale and the Hamilton Rating Scale for Depression, and an assessor severity index)) than on standard self-report measures (the State Trait Anxiety Inventory-Trait Anxiety, the Penn State Worry Questionnaire, and the Beck Depression Inventory). On the other hand, Robert's ratings in his

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daily diary also showed great improvement.

The following biographical information was collected on an as-available basis, gathered when possible from segments of the audio record. No formal background information was maintained for clients who participated in the GAD III clinical trial. All clients were assigned pseudonyms during the analysis, and identifying information (proper names, cities, places of business, etc.) discussed in the therapy record has been changed or withheld to preserve client anonymity.

Biographical Information. Robert came to treatment with concerns about feeling like a “pretender” and insecurity about his identity as a middle-aged adult. Robert described himself as being somewhere between a “factory worker” and a “scholar” (Session #1, 17:00 m). Very early in the therapy, Robert reported participating in erudite, intellectual pursuits—such as practicing Buddhism/eastern philosophy or teaching theater courses at a local university—but persistently fearing that he lacked the talent and sophistication to actually take part in these interests. He reported considerable struggles around assuming a position of authority, and talked extensively about worry and distress related to evaluating the students in the courses he taught.

Robert was the second youngest of four children, all brothers. He reported some significant discord in his relationships with his brothers and alluded to fighting with them considerably when he was younger. Robert indicated that he was widowed and that his marriage to his first wife produced two daughters who were now adults. Robert’s first wife was diagnosed with cancer and died suddenly, approximately 15 years before he presented for therapy. Early in treatment, Robert reported that he still had many unresolved feelings about her death and their relationship that sometimes impacted his current marriage.

Robert and his second wife, Terri (also a pseudonym), had been married for approximately 11 years prior to his coming to treatment. Terri was a professor at the same university where Robert worked as an instructor. While Robert noted that he and his wife communicated very openly and supported one another, there was considerable stress in the marriage. For Robert, much of this tension stemmed from the disparity between his and his wife’s levels of education/status (professor vs. instructor) at the university where they worked.

Robert communicated frequently with the therapist about feeling intellectually inadequate to Terri. Other major sources of anxiety Robert identified in his life included concerns that his loved ones (Terri, his daughters) would abandon him, fear/unresolved feelings about his mother’s death, and worry about his social interactions with new people.

Therapist. Therapy was administered by a male psychologist trained in administering the treatment protocol developed by T. D. Borkovec (the lead investigator in the trial) prior to the start of treatment. Borkovec provided weekly therapist supervision and review of therapy tapes to ensure adherence to the treatment protocol and to maintain the overall quality of the treatment.

Co-Investigators. Three graduate students, including the lead author (MAG), analyzed the cases. At the time of the project, all were enrolled in the clinical psychology program at Miami University and were active participants in Miami University’s Assimilation Research Group

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(ARG). ARG was a voluntary graduate student research group that met weekly during the academic semester to discuss and review psychotherapy research projects that used the assimilation model. Students who participated in ARG had extensive exposure to literature involving the assimilation model and frequently reviewed external and inter-department projects that featured the use of assimilation analysis.

Co-investigator duties included individually reviewing the audio record of each client's therapy, completing a rating sheet for each therapy session they reviewed, and participating in research meetings to construct assimilation model conceptualizations for each case. Supervision and oversight of the project was conducted by the lead author's then-academic advisor (WBS).

Materials

Outcome Measures. The outcome measures used to track fluctuations in the symptomatology of the clients studied in this project included a battery of self-report scales for depression and anxiety, an average daily rating of distress by clients (1 to 100), the Hamilton Anxiety Rating Scale (HARS; Hamilton, 1959) and Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) scores, and an index score (0 to 8 scale) of the Severity of Client Symptoms (SEV) as judged by a trained assessor (Table 2).

Included in the battery of self-report measures was the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990), a 16-item questionnaire designed to measure the frequency and intensity of worrying symptoms. Also included was the State-Trait Anxiety Inventory-Trait Scale (STAI-T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs; 1983), a 20-item questionnaire targeted at determining client proneness to anxious attitudes, beliefs, and behaviors. The Beck Depression Inventory (BDI; Beck & Steer; 1987), a 21-item questionnaire designed to measure the behavioral manifestations of depression and emotional distress, was also a part of the battery. Clients were administered the battery of outcome measures in separate, non-therapy meetings 2 weeks prior to the start and just following the end of therapy. As Table 2 shows, Robert pre-post change was very substantial on the assessor-rated HARS and HRSD and a global severity rating given by the assessor but smaller on these self-report measures.

Process Measure. The APES (Stiles et al., 1992; see Table 1) was used by the investigators in generating conceptualizations. The APES is an 8-stage description of degrees of assimilation between two of a client's internal voices, as manifested in the dialogue of therapy.

Procedures

Treatment. Clients in the GAD III project received were randomly assigned to either 14 sessions of applied relaxation/desensitization training, cognitive therapy, or a combination of both. To control the total amount of time clients in each condition were in treatment, the first 4 sessions of therapy were 2.0 hours in length; the remaining 10 sessions were 1.5 hours. The first 30 minutes of each session were devoted to non-directive, supportive listening to clients. During this time, therapists were instructed to "provide an accepting, nonjudgmental, empathic environment; to direct client attention to primary feelings; and to facilitate allowing and acceptance of affect, using supportive statements, reflective listening, and empathic

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communications" (Borkovec et al., 2002, p. 290). Robert, the case examined here, was assigned to the cognitive therapy condition and did not receive applied relaxation/desensitization training.

Remaining session time was used to conduct cognitive therapy informed by the work of Beck & Emery (1985). The cognitive therapy used in this study was characterized by the "Socratic method" (Borkovec et al., 2002, p. 290). The therapists used common cognitive restructuring techniques like logical analysis, examining evidence and probabilities, labeling logical errors, and decatastrophizing to help clients manage symptoms. There was an emphasis in each therapy case upon considering the likelihood of alternative, less negative outcomes to anxiety-provoking situations. Socratic questioning often involved therapists challenging client's exaggerations of threats in the world and/or tendency to self-criticize.

Clients were taught to self-identify environmental, psychological, and somatic cues associated with anxiety. They were told to approach their anxiety as a maladaptive pattern of managing negative affect and that they would be shown new ways of handling distress. Clients and therapists worked together to modify specific thoughts, beliefs, and assumptions connected to anxiety. Clients were also given homework. Typically, homework contained a prescriptive component encouraging clients to further explore alternative possibilities generated in session and consider novel ways of approaching anxiety-provoking situations. Other assignments required clients to engage in behaviors that would confirm alternative, adaptive beliefs about the world.

Case selection. Tapes of all therapy sessions were re-recorded in T.D. Borkovec's laboratory in August 2004. All of the material available from each therapy record was converted from analog audio tape to MP3 digital audio files. This conversion gave co-investigators easier access to the entire record of therapy sessions and allowed them to make more precise estimations about the beginning and end of segments in each client's speech.

Role of Co-Investigators. The co-investigators in this project read the study proposal and were aware of the stated goals and hypotheses. Additionally, they were given access to outcome measurement data (see Table 2). Co-investigators were told to use their clinical judgment, familiarity with the assimilation model, and insights from previous research experience to develop a narrative account of the therapy process grounded in observations from client speech. Their task was framed as theory-building: incorporating new observations into the assimilation model to expand its scope and utility. Among other things, this procedure identified specific passages in each session that appeared clinically or theoretically significant.

Case Analysis. The analysis occurred in two phases. In the first, a research team consisting of the lead author and two co-investigators used assimilation analysis (see Stiles et al., 1992; Stiles & Angus, 2001) to identify and track client voices in the recorded sessions.

Assimilation analysis has four major steps. In the first step, *cataloguing*, co-investigators reviewed available material to cultivate a familiarity with its major features. In the second stage, *identification*, co-investigators used the familiarity they had gained to begin labeling major themes or voices that were present in the client dialogue. In the third stage, *grounding*, co-

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investigators selected passages—the words spoken by clients—to support the conclusions that they had identified. In the final step, co-investigators assigned an APES rating to each passage they had selected. APES ratings were meant as an estimation of the degree to which a client's internal voices had begun to appear (and work) together. When shared in team meetings, ratings enabled investigators to construct detailed descriptions of the assimilation process that explicitly connected observations to features/stages of the assimilation model.

Co-investigators independently listened to all available sessions of the therapy record, and made notes regarding their observations and emerging conceptualization of the case. Co-investigators noted evidence of what they thought to be the speaking of significant voices in client speech. They took detailed notes, which included the specific times of each excerpt in the audio record, a transcription of the excerpt, and a brief written commentary explaining why they felt the excerpt was significant.

The team met a total of 3 times, or once per every 5 hours of the therapy record that was analyzed. Team meetings lasted approximately 2 hours. The lead investigator took extensive minutes detailing the topics of discussion covered during each meeting. After the team had reviewed all available case material, team members gave their notes to the lead investigator.

In the second phase of the analysis, the lead investigator used each team member's notes to conduct a second analysis of the data. The lead investigator listened to the audio records of the therapy case again—in many instances multiple times. During this review, particular attention was paid to excerpts that the team had determined to be of relevance to the assimilation model. After listening to those passages repeatedly, the lead investigator selected a subset of these excerpts and arranged them to create a narrative that described the client's experience in treatment. Additionally, the lead investigator noted phrases within the excerpts that appeared to be manifestations of internal voices and provided a narrative explanation for these ratings. Throughout this process, the lead investigator consulted regularly with his supervisor (WBS), who helped to elaborate and expand his conclusions about the data.

In keeping with the logic of theory-building case research (Stiles, 2003, 2009), the intent of both phases was to make inferences—grounded in actual passages from the cases—that served to expand the model's scope and applicability. The goal was to create a coherent account of treating GAD that respected co-investigator observations as well as previous iterations of the assimilation model.

RESULTS

Vulnerability as a Key Concept

Before we describe Robert's course in therapy, we review some key concepts that emerged from our analysis of this case as new (or newly important) in assimilation theory and seemed particularly helpful for understanding the Robert's anxiety and treatment. These concepts also appeared important in the other GAD cases our group studied in this project (Gray, 2010). They represent abductions to assimilation theory—new concepts and tenets that, if accepted,

would render these observations consistent with the theory while respecting observations already explained by the theory.

Our analysis suggested Robert's anxiety was connected to an exaggerated sense of *vulnerability*, rooted in a perception that he was highly vulnerable to potential threats in the world. This sense of vulnerability appeared to be maintained by entrenched patterns of self-criticism, the result of a contentious dialogue between a *critic* voice (written in italicized text throughout) and a **criticized** (bold text) voice—the addressed representative of the client's community of other voices.

For readability, we speak of Robert's *critic* voice and **criticized** voice in the singular. However, we acknowledge that such internal voices are not fully unitary. Theoretically, such voices are composed of traces of many experiences that are bound together by meaning bridges to varying degrees (Stiles, 2011). If bonds are loose or the voices are fragmented—for example, if the person has experienced several distinctly different modes of severe criticism—then the person may speak from several partially distinct critic or criticized voices (see Osatuke & Stiles, 2006, for a discussion of more extensive fragmentation of internal voices).

Unexpectedly (to us), the anxiety itself seemed not to represent direct confrontations between the *critic* and **criticized** voices, but rather confrontations of the **criticized** self with particular circumstances in the environment to which the self had been rendered vulnerable by the *critic* previously. Robert's affect in immediate response to the harsh expressions by the *critic* was a sort of downtrodden acceptance of his own inability to cope (and perhaps some suppressed resentment). But the later effect of this self-criticism was to make Robert vulnerable to intense anxiety when he confronted or even anticipated those circumstances in his daily life. The following section offers examples. The *critic* voice in Robert generally seemed to represent a constellation of experiences with a critical parent. That is, it could be understood as a hostile introject (Watson & Greenberg, 1998).

Treatment Progress

The *critic* voice (in italicized text) emerged early on in the dialogue of Robert's first session of therapy, immediately after a description of his basic presenting concerns. Robert was unhappy with his performance during his assessment for inclusion in the clinical trial, and he stated the following:

> **Robert:** *I am disappointed in myself as a patient!* During the lab test [screening for inclusion in the GAD III project], I couldn't do anything. I didn't feel anything that [the assessor] she was suggesting that I think about. I couldn't generate anything! (Session #1, 37:27)

Later in the same session, the **criticized** voice (in bold text) appeared to emerge and speak as Robert talked about a significant educational experience in his background: failing math courses during his first attempt at college and being forced to withdraw from an engineering program.

> **Robert:** I got out of the math area, which took me out of the engineering area, which is

> where I really wanted to go. I wanted to go to architectural school. And then I wound up in a whole new area which is called liberal arts. The humanities, arts—things like that—and **I never felt quite competent or qualified there. I felt as if my true workings are somewhere else. I mean, I have a tremendous, deep love for that which I engage in**, **but I don't feel as though I have the kind of knowledge or ability to really share in it to my satisfaction**. (Session #1, 42:33)

As he and the therapist began to explore his symptom history, Robert also indicated that he was concerned about the way he expressed anger. At first, he appeared to be concerned that he expressed too much anger to too small a number of (presumably) significant others in his life. As he continued to speak, Robert communicated a broader concern that his anger was possibly a byproduct of both his failure in his first attempt at college, as well as even earlier life experiences. Robert's tone during this passage suggested the speaking of the *critic* voice. It was as if this voice was chastising Robert both for having failed at college and for continuing to be bothered by this failure:

> **Robert:** The interesting thing about it is that I really express a lot of anger to a significantly small number of people. A small number, but it's significant. What disturbs me is…I ask this question: "*Is the anger something I've always had, or is it something that has evolved out of whatever this issue is, this problem?" I haven't figured that out yet. I think sometimes it goes back to wanting to be that engineer, wanting to have performed a 100% in my calculus class, having been pulled out of that college and into the theater with my brothers*. Instead, somehow or another, it goes back to things, or even before, really. (Session #1, 1:20:30)

The association of anger with the speaking of a *critic* voice seemed significant. Robert's statements seemed indicative of APES Stage 2, vague awareness/emergence. Robert was able to articulate some recognition of the connection between his agitation and the speaking of a *critic* voice, but lacked a clear understanding of why this unpleasant affect was generated.

In Session #3, the *critic* voice emerged at the beginning of the session, and it again expressed a lack of confidence about Robert's performance as a therapy client.

> **Robert:** I got us off track, in a sense, in a way...
>
> **Therapist:** [bewildered] That's fascinating, isn't it?
>
> **Robert:** *I sense that there's an agenda here, if you will, and you just expressed it to me. But I've got a feeling that we've gotten into talking and somehow or another we've deviated from the agenda*….Is there a program, and obviously there is, or a specific approach to one's personal anxiety that we are somehow or another avoiding because we've gotten into my specific case? I'm not sure if I'm saying that correctly, so I hope you understood what I'm saying… I felt as if we both got cheated or something, in a way…
>
> **Therapist:** That's interesting.
>
> **Robert:** *We're not doing what we're supposed to do.*

> **Therapist:** How did you feel "cheated?"
>
> **Robert:** Well, to be honest, *I feel like there's an agenda, and I didn't get the agenda.* (Session #3, 3:01)

Later in that session, during a discussion about feelings of inferiority and inadequacy when Robert compared himself to his wife, the **criticized** voice was identified. Robert began by stating that he had gotten into the "trap" of making downward comparisons between himself and his wife—which seemed to be the speaking of the *critic* voice. As the passage continued, Robert's tone changed and he came across as downtrodden. It was as if he felt defeated and worn down by his self-imposed competitiveness with his wife, and that this was made worse by his admission that he believed he had "perpetuated" this dynamic in their relationship.

> **Robert:** *I have gotten deeper in the trap over the past 11 years that I have been with Terri.* It's by no means her fault, it's just that she really exudes and demonstrates so much confidence in what she does and where she's at, that [voice lowers] **it just straps me. I just don't know what to do with it. It's really very difficult. It's just really hard to work my way out of it. I have certainly thought often "Well, just walk away. Leave the relationship."** I know she has thought that, but that's just not the answer for me. It might be the answer for her, but it's not for me—because it's not her that's doing anything to me. *It's something obviously that I have perpetuated.* (Session # 3, 25:27)

Voice quality played a key role in the identification of the *critic* and the **criticized** voices in this passage. The shift in Robert's tone that was labeled the speaking of the **criticized** voice was dramatic. The volume of his voice dropped significantly, and the rate at which he spoke was more slow and deliberate. The pattern in the excerpt of dialogue observed here—the quick back-and-forth speaking of the *critic* and **criticized** voices—could be characterized as the worry and rumination that are hallmark features of GAD.

The *critic* voice took a derogating position towards Robert's concern about his marriage, prompting a response from the **criticized** voice on this point, which was then responded to again by the *critic* voice. The interaction of the voices, the tension between the different perspectives on the same experience, appeared to produce the emotional distress associated with anxiety. Robert appeared aware that the conflicting perspectives that were expressed about his relationship were problematic; however, he was not yet aware that the quality of the dialogue between the voices was in and of itself problematic and contributed to the experience of anxiety.

A similar pattern emerged later in the same session, this time in reference to Robert's professional identity.

> **Robert:** *[sarcastic]Where I have learned to be in quotes "comfortable*," another way of putting this as opposed to the director/producer, is that Terri is a creator, and **I'm a** [pause, voice lowers] **technician**. Take a very good example: she presently is getting very involved in making her own paper and she's doing a wonderful job—she's very excited about it and I'm really excited for her…I'll do all of the work necessary to get her to then go ahead and create her paper. I'll do [pause]…*I have sort of become—not sort of become, I AM [client*

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> *emphasis], a handyman*. And **I don't mind that, but somehow or another, I have allowed myself to get trapped in that role**. As Terri used to say, I am the "man behind the camera," which was a phrase I used many years ago instead of "the person in front of the camera."
>
> **Therapist**: So even the phrases "handyman," "technician," and "man behind the camera" are the kind of iconic representations that the business of automatic thoughts is meant to evoke.
>
> **Robert:** Uh-huh
>
> **Therapist:** We want to get you listening to yourself in a way that allows you to hear those phrases, the ones that have extensive meaning and define you in your relationship with Terri and in the rest of your world. So, you say to yourself, "I'm a handyman, I'm a technician, I'm the man behind the camera." What does that mean? What's true if those things are true?
>
> **Robert:** [voice lowers] **I can serve people, that's one of the truths that comes out of it. I can serve people; I can do assignments for people. That's what happens**.
>
> **Therapist:** How does it feel to say that?
>
> **Robert:** Well, I don't know. It's hard to say. **I get a lot of pleasure out of it in a way because I think bring pleasure to people by doing these things**. *But, at the same time, I sort of have allowed myself to become pigeonholed and comfortable in those places* but **I'm not happy with it anymore**. (Session #3, 30:07)

It appeared that the *critic* and the **criticized** voice were both present in this passage, and that they both spoke about the same topic, so in this limited sense they were responding to each other. The *critic* voice expressed some disapproval, with sarcasm, of Robert's role in his work and marriage, and the defeated-sounding **criticized** voice responded defensively to these those statements. There was little evidence of a shared perspective or joint action by the two voices, and this lack of harmony between the voices appeared central to Robert's anxiety. The sarcasm of the *critic* voice—its derisive statements about Robert's skill as an artist—appeared to leave him feeling vulnerable and uncertain about his professional identity. Although his affective response in the moment was not anxiety, it potentially left him vulnerable to anxiety in circumstances that called for creative or artistic expression.

In Session #5, Robert and the therapist engaged in further exploration of the circumstances that surrounded the death of his first wife. It appeared that the link between that particular problematic experience and his ruminative symptoms of anxiety was becoming more evident.

> **Robert:** When she came out of the doctor's office when she was first diagnosed with cancer, her phrase on the way home was "I cannot do chemotherapy." And I said, "That's fine with me." Well, from that point forth, we spend the next 27 months pursuing whatever she was interested in doing to eradicate, cure, heal—whatever you want to call it—her condition. And she died, and I totally supported everything that she did. **I sometimes feel in a way I have, and maybe I'm wrong about this, that I certainly feel as if I stood up to a lot of scrutiny for allowing her to do what she chose to do and supporting that**. [I

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> experienced scrutiny] from her family, and some other people, too. So I say to myself, [voice lowers] "*She chose to do this, I supported it.*" I really didn't have any rights in saying you can't do that, this is what I want you do with your life. I wonder if either of us had any control in what was going on….But my wife died, and *I sometimes wonder if that was her way to free herself from me, or to free me up*. (Session #5, 32:08)

The therapist responded to the above passage with a challenging intervention. He suggested to Robert that the shifting of positions he engaged in while speaking—i.e., the frequent back-and-forth dialogue between the *critic* and the **criticized** position—kept him from moving forward and resolving the many problematic experiences in his life. That is, the therapist confronted Robert's rumination, a common symptom of GAD.

> **Therapist:** It's like even-handed therapists or diagnosticians. They would say, "On the one hand it could be depression, but on the other hand, maybe it could be anxiety." The point is that they saw all of the options, but committed to none. That they were the kind of diagnostician that always seem kind of confused. They were never wrong in a sense because they had always considered the possibilities, but they never pursued a path very aggressively. In a sense, you're so good at thinking and so capable of seeing options that one of the ways that I experience talking to you is that every time an "either/or" comes up, both the "either" and the "or" get mentioned, and then we pass to something else having done exactly that: mentioned them both. That's the kind of thing that I think might help keep somebody distant from his feelings. (Session #5, 33:55)

When Robert responded to the challenge a few moments later, the *critic* voice, speaking very authoritatively, came through in his speech. The *critic* voice initially minimized Robert's recent struggles, implying that they were mundane parts of everyday life that did not require special attention.

> **Robert:** *Excuse me, but truly, I ultimately believe this is part of life. All of this pain, all of this whatever we're going through, and so I can't stop, I can't stop—not to smell the roses, but I can't stop to dwell on all this stuff because I don't have the time to*! That might be why I'm avoiding. (Session #5, 39:31)

After a brief exchange about the structure of cognitive therapy, Robert and the therapist came back to this topic.

> **Therapist:** These things touched you. You FELT something about them.
>
> **Robert:** [sarcastic] *Lots of things touch me. Lots of things do. Whistle "Miss America" and I'll start crying—I mean, I was raised on it.*
>
> **Therapist:** Weren't you saying, just a minute ago, that you don't have time to stop and feel because why?
>
> **Robert:** **Well, it's not that I don't have time to feel, it's that I don't want to take or have the time to dwell on the feelings**. I certainly do foster…
>
> **Therapist:** What would happen if you dwelled on the feelings? What are you going to

> miss?
>
> **Robert:** Well, it's a question: I am doing what I'm doing to avoid the feelings, or do I avoid the feelings because I have so much to do? **I don't know what would happen if I dwelled upon the feelings**.
>
> **Therapist:** Well, then dwell on them and see.
>
> **Robert:** I mean no, I mean I take that back. **I was going to say I'm not worried about them, but maybe I am** [laughs]. (Session #5, 41:25)

As Robert was challenged very directly by the therapist about his tendency to ruminate about important emotional matters in his life, both the *critic* and the **criticized** voice had speaking turns. The *critic* voice emerged early in the exchange, snapping sarcastically at the therapist when he attempted to focus Robert upon his emotional experience. Later in the dialogue, there was evidence of the overwhelmed **criticized** voice, which appeared as Robert began to reflect upon his trouble with accepting and attending to negative feelings about his identity.

Some progress was observed in Session #9. There were indications that Robert was working to challenge the *critic* voice's urging that he needed to ignore or suppress negative affect. He described a situation where he and his wife hosted a community meeting/party at their house over the previous weekend, which had included a "check-in" exercise. As part of this exercise, each attendee shared the recent events of their lives, and this experience proved to be surprisingly powerful for Robert.

> **Robert:** I felt actually pretty good, and **I passed the first time and wasn't going to talk because I didn't feel that there was anything to talk about**. I didn't feel good or bad—that's not true—I felt pretty good, actually. And then it came around, with everyone just assuming that I was passing to pick up the tail end rather than start off the discussion. So it came around finally after everyone had spoken and I thought, "Well, maybe I do have things to share." **So, I shared the loss of my mother and my cat and…[3 second pause] I actually cried quite a bit.** *As I told you, I always cry in public and I really did. And…uhh…that, that was fine.* But during the whole weekend, I got down. Not the whole time, but every now and again and I would retreat to [my wife and I's] room to just lie down and sort of get out of it. (Session #9, 4:57)

At the beginning of the passage, the meek-sounding **criticized** voice appears to suggest that there was nothing for Robert to share with others at the meeting and that the recent struggles in his life (especially the grief associated with the very recent death of his mother) were not acceptable events to share. Later in the passage, Robert recounted that he eventually did share some of the distress he had been feeling with the group and he indicated that participating in this process, while painful, was cathartic. After this information is related, however, a *critic* voice appeared to communicate some disapproval of Robert's outward display of emotion.

The *critic* voice's appearance was marked by some of the same disfluencies of speech that were contained in earlier passages. Like previous examples, the *critic* voice's comments

seemed aimed at shaming Robert for so publicly expressing his feelings about his recent losses. At the same time, the speaking of the *critic* voice was less intrusive than it had been in previous sessions. Instead of completely cutting off the speech of the **criticized** voice, the *critic* voice allowed it to hold the floor and express its perspective—an indication that there was some sort of burgeoning, albeit not clearly defined relationship between the two positions. In assimilation terms, this type of relationship was best characterized as being at APES stage 2, Vague Awareness/Emergence.

There is a similar exchange later in the same session. In this passage, Robert reflected on his experience in treatment and learning to cope with his anxiety, and his speech further suggested some growing awareness of /communication between the *critic* and the **criticized** voice.

> **Robert: If we're in a panic, if we're panicking, if we're upset, if we're afraid, if we think we're going to die…if we think we're going to die or any of these thoughts** [4 second pause]. *To show my ignorance, I'll ask the question*: Can we ever change that, those thoughts? I understand how we can act following the thoughts, responding to the thoughts, but are we…*Is one of the purposes of this to change it, or are we pushing it back further and…hopefully finding enough forefront material to in quotes "keep us going?"* (Session #9, 18:43)

Initially, the **criticized** voice expressed concern about the set of automatic negative thoughts Robert frequently experienced. Following this, it appeared as though the *critic* voice emerged in Robert's speech and communicated doubt (with some significant sarcasm) about the value of participating in the hard work of therapy. As it had in earlier in treatment, the *critic* voice appeared to leave Robert vulnerable to being overwhelmed by worry. It communicated doubt about Robert's capacity to ever make meaningful changes his life, and in so doing, suggested that his participation in treatment might be pointless.

There was some evidence of progress, however. This excerpt suggested that the *critic* voice, which is typically suppressive and often spoke to prevent the expression of negative affect, was softening some and allowing the **criticized** voice room for expression. The back-and-forth speaking of the two voices was formally similar to the rumination pattern observed in earlier sessions of the therapy; however, the shifting between the two voices occurred at a less rapid rate. Additionally, the *critic* voice appeared to be less rigid in its suppression of the negative affect typically associated with the speaking of the **criticized** voice. Robert was becoming more capable of expressing anxious, unpleasant feelings productively in session, and was closer to resolving some of his problematic experiences.

A significant turning point in Robert's progress in treatment occurred in Session #10. Robert and the therapist were discussing his recent decision to take some piano lessons for recreation, and their exploration of the subject lead to the following exchange.

> **Robert:** I had in my life spent literally 30 minutes—in my whole life 30 minutes—sitting at the keyboard trying to figure out the keys in relation to the music, because I don't read music. So I put a lot of time and practice into it and um, I think I was a bit discouraged

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> because I couldn't read both hands simultaneously which was a surprise to me because I usually function well with both hands. **So, just before I came in today I sat down and started playing and I just said, "let go." And all of a sudden both hands started playing!**
>
> **Therapist:** [laughs loudly]
>
> **Robert: This was wonderful! It was a really exciting moment—I got really excited!**
>
> **Therapist:** That's marvelous…
>
> **Robert:** I mean, what was I playing? **Just this little "da da da dah," but all of sudden both hands went! And I thought, "Son of a gun. Where does this go?"** I thought, "Gee, I might actually be able to play this piece someday, maybe." (Session #10, 4:45)

Robert then indicates:

> **Robert:** *So I was playing and I was really frustrated the other day and I was thinking, "I can't do this kind of thing."* **But today, I stuck to it for just about a half hour and all of a sudden both hands would go! And I thought, "God, this is nice!"** So, I don't know. It was a reflection of other things that are happening that I'm feeling very good about. (Session #9, 6:14)

And a few moments later:

> **Therapist:** Tell me, I guess, to bring it back to you, what does that set to percolating in your own head? What's your gut feeling?
>
> **Robert:** [6 second pause] **The idea of letting go, and really allowing myself to really experience something by myself and allowing myself to really uh**…*at [a subjective rating of] stage "1 minus 4 million"*…**to allow myself to break through this thing of…not expressing myself in a sense.** (Session #9, 10:30)

Perhaps more clearly than in any other portion of the audio record, this passage typified the assimilation pattern of significant voices within Robert's internal community. The **criticized** voice, which had previously been tentative and meek, erupts when Robert recounts being able to overcome his self-doubt and play the piano. The *critic* voice, which appeared peripherally in the passage, did not prevent the expression of the **criticized** voice. Also, it did not induce Robert's sense of vulnerability and self-doubt about his identity as an artist, as he reported the *critic* voice had done in earlier sessions.

It was significant that the change in the communication pattern of the voices occurred around Robert's decision to play a musical instrument. Previously in treatment (Session #3), the *critic* voice had derogated the **criticized** voice's interest in artistic pursuits. The *critic* voice branded the other voice with pejorative names like "technician" or "handyman," and communicated doubt that it was capable of genuine artistic expression like a "creator." Here, the *critic* remained largely silent, allowing the previously **criticized** voice to express its perspective

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with considerable exuberance.

Later in the same session, Robert and the therapist exchanged observations about his experience with the piano and generalized to other struggles in his life. It was at this point in the therapy record that Robert began to demonstrate a capacity to speak about anxiety in clearly defined way. That is, there was evidence of a meaning bridge (APES Stage 3) between the *critic* voice and other voices in Robert's community. In this passage, the *critic* and **criticized** voices appeared to have some shared understanding that Robert's judging behavior contributed to the anxiety he felt.

> **Therapist:** One of way of looking at this is that you have been trying to take Terri's obstinate difference from your expectations and get her broken self to fit how it is, how it's always been for you…and one of the things you've said most clearly today is that it really hurts doing that. It hasn't paid off the way that you've tried it and it gives you a bellyache [a reference to Robert's frequent complaints of intestinal distress/somaticizing]
>
> **Robert:** [4 second pause] Well, it does. **I think this concept of fixing things, I think that has been my role in relationships for ever: with my mother, with my previous in-laws, with my brothers, with my daughter. Of course, you never live as intimately with those people as I have with Terri, or my previous wife. In all of those relationships—this is something I wanted to tell you—***I have had this…compulsion…[volume of voice increases] TO JUDGE, which drives me [volume increase]* **TO FIX**. Okay? I'm really, finally now making some headway in learning how not to judge people. I think I really did have a certain perspective on how things should be, almost if you will, a techno-fix [a type of cognitive distortion identified in the treatment protocol] concept, which I think is a big side of me. (Session #10, 1:00:30)

The *critic* voice was responded to by the speaking of a **criticized voice**, and without interruption. An exasperated-sounding **criticized** voice communicated recognition that the speaking of the *critic* voice was problematic when its speaking was followed by arbitrary judgment of significant others in Robert's life. It was a clear statement of the problematic relationship between the *critic* and **criticized** voice—the *critic*'s tendency to quickly perceive flaws in the world left Robert feeling vulnerable and uneasy. As expressed by the **criticized** voice, Robert's recourse was to become uncomfortable and try to "fix" others around him.

For Robert, the term "techno-fix" was a meaning bridge or point of shared understanding between *critic* and **criticized** voices. A "techno-fix" described the rigid manner in which the *critic* voice judged others as well as the **criticized** voice. It referenced experiences when the *critic* gave cold, often inconsiderate feedback to others about how it felt that they could improve their behavior. In the therapy dialogue, it was shorthand for describing how the *critic* voice expressed itself maladaptively in interpersonal relationships. The term was related to earlier sessions of the therapy (#3), during which Robert indicated that "technician" was one of the derogatory titles that the *critic* voice used to describe the **criticized** voice—the part of Robert that longed to be more outwardly creative and artistic but was frequently suppressed.

At a different point in Session #10, Robert discussed the origin of the *critic* voice. After describing his “compulsion” to judge others harshly, Robert made an immediate connection to his relationship with his mother.

> **Robert:** The judgment practice, it goes back to a sort of where-do-we-come-from-thing. It was something that my mother did her whole life, and it was very difficult for me to deal with that. And the reason that it was so difficult to deal with was that I was fully aware that I was picking up the same pattern.

Therapist: [crosstalk] Tell me about that. How did she judge people? How did you pick it up? What got judged?

> **Robert:** In her way, it was just on a very surface level. She would see somebody and say, “God, look at the way they’re dressed!” Or, “Look at that person, they’re so thin!” Or, “Look at that person, they’re so fat!” No matter what it was, it wasn’t right. Nothing was correct. **And it was constant, it really was constant. And I spent a good deal of the last 35 year fighting that, seriously. Trying to say to my mother, “Mom, can you not just enjoy the world as it is and quit trying, in some way or another, to describe it?”** It took me a long time to grow up, to recognize that was the way my mother was. And the reason was because I knew if I looked in that mirror, I was the same person, and I couldn’t stand it. I could accept that she was that way, but I couldn’t accept that I was that way. (Session #10, 1:09:09)

After some reflection, Robert and the therapist discuss this issue further:

> **Therapist**: A person lives in a world where it is impossible to do something right. That’s definitional. What’s a good strategy? How should you live?
>
> **Robert:** [3 second pause] Don’t?
>
> **Therapist:** Uh-huh. Minimize what you do.
>
> **Robert:** **That’s a good. That’s a good point. Yes, that’s very nice. That’s what she did do, and that’s what I’ve done. Thank you, that’s very nice.** (Session #10, 1:10:21)

This passage gave co-investigators an indication about the conditions that gave rise to the *critic* voice. As Robert described it, the *critic* voice that he could identify as a part of himself was a direct remnant of his experience of his mother’s habitual criticism of him and others.

Rather than having resolved and integrated his experiences with his mother, Robert appeared to have instead internalized them. He had adopted and spoke with his mother’s critical voice as his own, a realization that Robert indicated was very upsetting to him throughout his life. That is, Robert’s mother's critical voice wasn't accessible to him as a resource. Instead, it intruded and contributed to Robert’s self-criticism at times when it was triggered.

In Session #11, Robert gave some further indication about the origin of the *critic* voice connecting in significant ways to his relationship with his mother. He indicated to the therapist

that Terri had confessed to him that she was physically abused as a child by her mother. Robert was confused and skeptical about Terri's disclosure, and he stated the following:

> **Robert:** *That [the abuse] sounds pretty bizarre to me, because I had a mother that never raised a finger to four sons. Ever. In her whole life. And that doesn't mean we came out [3 second pause] any more aggressive or any more passive. That just never happened in our lives.*
>
> **Therapist:** Perhaps it's a projection on my part based on what you said last week, but I fancy your mother wielded a scalpel more than she did a saber…
>
> **Robert:** I don't know. I'm trying to figure that out, too.
>
> **Therapist:** Well, what I know about your mother is what you've told me. [crosstalk] What you've said is that she was pervasively…critical about everything and not easy to please. And I'm just thinking that her…that the difficulties she would present you with would be verbal ones. She wouldn't induce pain by hitting you, but I got the impression that there was very little pleasing her.
>
> **Robert:** **But those are subtle, at least to a child**… (Session #11, 40:27)

A few moments later, the therapist refocused Robert, which led to this related exchange:

> **Robert:** Um, well I think what I'm trying to experience is really, in relation to, say, what you just mentioned about my mother and what I've said about her, is really get away from practicing that mode of connecting with other people, which is being judgmental.
>
> **Therapist:** Leading to needing to fix….
>
> **Robert:** Well, maybe. But just being judgmental, on its own, I feel is very destructive. Everything that [my wife] and I have tried to practice over the past number of years has been to get away from that, but **I have discovered that I am very judgmental**. **So I'm trying, really to stop doing that, because I've discovered that part of it is a real defense mechanism. It's a real way of protecting myself. Noticing that I feel as though I've never mastered anything, so it's a cover up for being [voice lowers]…exposed.** (Session #11, 44:37)

In this passage, the *critic* voice began by dismissively talking about Terri's experience, and doubting and dismissing it as "bizarre." The **criticized** voice then responded to the therapist's attempt to reframe its childhood experiences with Robert's mother, who herself was very critical and demanding. A few moments later, the **criticized** voice was able to comment on the position taken by the *critic* voice in the prior exchange, and could recognize that the speaking of that voice was judgmental and defensive.

In light of the discussion of the dynamics of Robert's early relationship with his mother and the way those features affected his current life, this passage suggested the beginnings of insight (APES Stage 4). There was recognition of the presence of the two voices, as well as

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some rudimentary understanding of the way that the communication style of the voices contributed to Robert's anxiety symptoms.

The **criticized** voice, with the aid of the therapist, appeared able to reflect on the *critic*'s expressions. The **criticized** voice communicated some understanding of the experiences that were responsible for its creation, namely Robert's relationship with his very demanding mother.

Additionally, it reflected on the way that the *critic* voice, with its dismissive and judgmental tone, mirrored the speaking of his mother, as well as the way that this voice served a basically self-protective, albeit maladaptive, defensive function. As described in this particular moment in the therapy, the *critic* voice often spoke to prevent the speaking of the **criticized** voice—it attacked preemptively to prevent the triggering of experiences associated with inadequacy and a lack of competence.

In Session #13, Robert and the therapist expanded on this idea. In these passages, a **criticized** voice reflected on avoiding new experiences as a strategy to prevent triggering anxiety.

> **Robert: What's really happening for me is that thing that I experience as boredom or rejection is really my lack of curiosity. I just started thinking about this recently. Maybe it's my mother's role of not being interested in anything. I may not be interested in anything for fear of failing, of course. Then, I don't have to demonstrate [anything].** *I can be a total failure instead of failing at all of these nice little things in life we can do.* **As a consequence, I refrain from being or getting curious about things. I sort of think, if I may say this to you and I'm sure you won't take this personally, but I don't know if I've ever talked to anybody this much in many, many years. But, I don't know that I would ever engage with anybody this much [client emphasis] EXCEPT for this process. And that disturbs me—I'm upset about that!** (Session #13, 1:06:30)

And later in the session:

> **Robert: But there is a spark missing, and I know that you can't give me a spark, but just saying I'm beginning to understand that there's something to do with my lack of curiosity. That's the reason I won't surge ahead—it probably has something to do with a sense of failing, so I won't get excited about anything enough to go after it.** (Session #13, 1:09:32)

In both of these sections, the **criticized** voice seemed to be communicating, in a much more direct way than it had previously, a recognition of its tendency to encourage avoidance. It was as if, anticipating the disappointment of potential failure, this part of Robert communicated a preference for retreating from opportunities to have contact with novel experiences.

While this type of speaking from the voice was basically protective in that it kept Robert from ever failing at what he called "all these nice little things in life we can do," it served to exacerbate, not reduce, his anxious distress. By feeling vulnerable and therefore adopting an avoidant stance, the **criticized** voice was unable to have contact with potentially efficacy-building experiences. Missing out on these opportunities, the **criticized** voice was prevented

from assimilating with other voices in Robert's community. Additionally, maintaining an avoidant stance kept the **criticized** voice in a subordinate position relative to the *critic* voice, thus making it difficult to challenge this voice when it spoke.

This dynamic between his internal voices kept Robert stuck in his anxious symptoms. The **criticized** voice, which was passive and struggled with assertiveness, was nevertheless the center of Robert's experience—it was the perspective from which he most often viewed the world (see Osatuke et al, 2007 for a summary of this idea). This voice was significantly influenced, however, by the speaking of the *critic* voice, which was active and aggressive. The *critic* voice often belittled expressions of interest by the **criticized** voice, indicating that Robert would fail if he tried new things or and that he lacked the intellectual resources to be successful. Robert could readily identify, in multiple passages throughout the final five sessions of therapy, that the style and content of the *critic* voice was similar to a voice used by his mother, whom he identified as hypercritical and very difficult to please.

In order for there to be a reduction in Robert's anxiety, it appeared that treatment needed to focus on two distinct elements: (1) encouraging Robert to challenge the speaking of the **criticized** voice and be proactive in approaching novel, rewarding experiences in the world, and (2) aiding him in controlling, perhaps through active suppression, the harsh speaking of the *critic* voice. Not coincidentally, these two treatment foci directly correspond to a cognitive-behavioral treatment protocol, one which would emphasize behavior modification to as a means of extinguishing avoidance of feared situations, as well as a cognitive restructuring component aimed at challenging a client's distorted thoughts.

There was some evidence in the final session, #14, that Robert was making some progress along these lines. In the following passage, he and therapist explored his often automatic negative response to conflict in his marriage.

> **Robert:** **What struck me is, "Why have I been doing this to myself?"**
>
> **Therapist:** Why have you been making the assumption that if two people don't connect, it has to be you?
>
> **Robert:** [stepping on therapist's last word] **It's me. It's me. It's the same thing with Terri. I really have thought that I'm the one who's wrong. I'm the one who's weaker, I'm the dumber one—I'm all of those things. And I'm sure I'm going to run into people where all those conditions could exist, but not necessarily all at once nor all the time.**
>
> **Therapist:** Yeah, Abe Lincoln did say something about that.
>
> **Robert:** **Yeah, and I think I have…spent all my life doing that to myself**. It just struck me, just now. So this isn't all in vain! [laughs]
>
> **Therapist:** [laughing] Well, I never thought it was, but...
>
> **Robert:** **That's the first light bulb** [i.e. a moment of insight] **that's hit me in a while.**

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And now the question is, of course, what can I do with that? (Session #14, 50:57)

With the help of the therapist, the **criticized** voice appeared to be emboldened in challenging the speaking of the *critic* voice. Rather than accepting the idea that any conflict in Robert's marital relationship was evidence of a personal and exclusive failure on his part (which was the implied perspective of the *critic* voice), the **criticized** voice was able to challenge that assumption and contemplate taking some sort of alternative, presumably less self-defeating action to improve Robert's life circumstances.

It was significant that at the end of this session, Robert and his therapist had an extended discussion about Robert and Terri pursuing marital therapy together. Viewed in light of Robert's tendency to retreat from proactive, health promoting action, his willingness to pursue a resolution of his marital conflict appeared to be a marker of overall therapeutic progress.

DISCUSSION

Robert's *critic* voice was noxious and its speaking seemed to maintain his sense of incompetence and hence his vulnerability to perceived threats in the world. Guided by cognitive therapy interventions initiated by the therapist, the *critic* voice was identified and characterized as irrational and distorted, which allowed it to be challenged by other, **criticized** voices in the community. The result of this challenge was a reorganized relationship between the *critic* voice and the other voices in the community. The *critic* voice remained active and would still periodically be expressed in client speech. However, because this voice was more smoothly integrated within the larger set voices in the community, the affect generated when it spoke was less dysphoric.

Description of Therapeutic Progress Using the APES

The *critic* voices appeared to be challenged and contained by Robert, moving through Stages 1 to 4 of the APES sequence. At the outset of treatment, the *critic* voice served to increase his vulnerability to perceived threats in the world. In labeling the *critic* voice as problematic, Robert and his therapist created an explicit goal for the remainder of their time in treatment: empowering other voices in the community to contain the speaking of the *critic* voice. The c*ritic* voice initially labeled Robert a "technician" and "handyman," derogating his ability as an artist. It suggested that Robert was capable only of aiding in the artistic contributions of others. With the help of cognitive therapy interventions initiated by the therapist, the *critic* voice was identified as irrational and distorted, which allowed it to be challenged by **criticized** voices in the community. Eventually, Robert forced himself to play the piano, actively working against the impulse to follow the urging of *critic* voice. The result was a strong sense of accomplishment and a sense that Robert's anxiety would likely decrease if he continued to confront the self-censorship advocated by the *critic* voice. That is, the challenge yielded a reorganized relationship between the *critic* voice and the other voices in the community. The c*ritic* voice remained active and would still periodically be expressed in Robert's speech. However, because it more smoothly integrated within the larger set voices in the community, the vulnerability generated when it spoke was reduced.

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Therapeutic progress and symptom reduction were thought to correspond with Robert's capacity to use logic to recognize and correct cognitive distortions. As treatment proceeded, Robert reflected on the scope and origins of his trouble with anxiety. Additionally, he had time to learn the core concepts and terminology associated with cognitive-behavioral therapy. A central theme in the cognitive therapy component used in the GAD III trial was that psychological distress was often the result of distorted, self-defeating, or illogical ways of making sense of events in the world. Robert received challenges via Socratic questioning from the therapist to examine his specific interpretations of anxiety-provoking events and consider how these interpretations served to perpetuate or intensify his symptoms.

Using the framework provided by the APES, the most integral part of this process was the identification, first by the therapist and later by Robert himself, that the speaking of the *critic* voice represented a cognitive distortion. That is, the c*ritic* voice was problematized by client and therapist. Viewed through the lens of the APES, this intervention could be thought of as movement from Stage 2 to Stage 3, Problem Statement/Clarification. In labeling the *critic* voice as problematic, Robert and the therapist created an explicit goal for the remainder of their time in treatment: empowering other voices in the community to contain the speaking of the *critic* voice.

Vulnerability and GAD

An unanticipated but significant observation in case material was that the *critic* voice did not appear to directly produce anxiety by attacking other voices in Robert's internal community. Rather, *critic* voice expressions induced a sense of incompetence and hence vulnerability within him. In turn, this produced anxiety when he encountered or anticipated the relevant circumstances. By exacerbating Robert's belief that he could not perform competently, the *critic* effectively exaggerated potential threats in everyday situations (playing music, interacting with his wife).

To be clear, the *critic voice* was a "problematic" voice in the conventional sense that has been described in previous assimilation research (Brinegar et al., 2006; Stiles & Varvin, 1999). It was discrepant from other voices in Robert's community. When the *critic* addressed the **criticized** voice representative from the community, the affects generated were dysphoric and ranged from anger to sadness. However, expressions by the *critic* voice alone did not completely account for the production of the worry and free-floating anxiety that were characteristic of GAD.

In addition to angry, dysphoric affects, contact between the *critic* and the community of voices produced intense feelings of vulnerability. This sense of vulnerability was generally unpleasant for Robert, but was particularly troublesome because of how it impacted his future interactions in world. *Critic*-induced vulnerability reduced Robert's resilience in potentially threatening or even neutral situations, and thus was thought to be the intermediary step in the development and maintenance of his anxiety.

Critic Voices as Hostile Introjects

Another significant abduction was that the *critic* voice may be a hostile introject—an

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unwanted but persistent part of the self rooted in identification with a negative/abusive other. In Robert's case, it appeared to be his mother. In Session #10, he described her as judgmental and indicated that for her "no matter what it was, it wasn't right."

Hostile introjects are not personalized or owned by clients, and they are often experienced as imposing and intrusive. We hypothesize that they are organized around strong value conflicts within the client, and the expression of an introject is often at direct odds with the client's values and/or best interest.

A tentative formulation would suggest that as a part of identity development, voices are inter-generationally transmitted from parents to children. When an anxious or critical parent interacts in a rigid way with a child, the parent actually "gives" the child a *critic* voice—with all of its associated signs and meanings. In clients with GAD, the *critic* voice becomes a prominent, albeit problematic member of the internal community of voices that constitute the self.

Further exploration is needed to understand how and under what conditions *critic* voices assume a position of prominence in the internal community of voices of clients with GAD. Additional clarification about the mechanism of inter-generational transmission of internal voices would be valuable, as it is very likely that hostile introjects are integral to the etiology of many other psychological disorders.

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Table 1. Assimilation of Problematic Experiences Scale (APES)

0. Warded off/dissociated. Client seems unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or state switches.

1. Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or actively avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear.

2. Vague awareness/emergence. Client is aware of the problem but cannot formulate it clearly—can express it but cannot reflect on it. Affect includes intense psychological pain—fear, sadness, anger, disgust—associated with the problematic experience.

3. Problem statement/clarification. Content includes a clear statement of a problem--something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

4. Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Table 2. Pre- and Post Treatment Scores on Self-Reported Outcome Measures

Client		Scale						
		HARS	HRSD	STAI-T	PSWQ	BDI	SEV	Diary
Robert	Pre	20.5	17	51	49	18	4.5	14.88
	Post	3	3	44	44	15	1.5	0

Note

HARS=Hamilton Anxiety Rating Scale (scores ≥14 are clinically significant);
HRSD=Hamilton Rating Scale for Depression
(scores >23, very severe; 19-22, severe; 14-18, moderate; 8-13, mild; <7, normal);
STAI-T=State Trait Anxiety Inventory-Trait Anxiety;
PSWQ=Penn State Worry Questionnaire (≥ 60 diagnostic of GAD);
BDI=Beck Depression Inventory (0-9, minimal; 10-16, mild; 17-29, moderate; 30-63, severe);
SEV= assessor severity index (0 to 8 scale) given to clients at the start and end of treatment; &
Diary=average self-report in client's daily diary rating (0 to 100).