Differences in Guided Imagery between High and Low Self-Critical Participants: Consensual Qualitative Research Analysis

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Abstract

As self-criticism is considered to be the major underlying factor of all sorts of psychopathology, it is meaningful to explore the differences between how people deal with their self-criticism based on their level of self-criticism. The aim of this study was to categorise descriptions and investigate differences between 5 high and 5 low self-critical participants in their self-critical, self-protective and self-compassionate imageries. The total sample consisted of 10 university students, who were selected from a larger sample of 88 participants based on their extreme score from The Forms of Self-Criticising/ Attacking and Self-Reassuring Scale. For analysis, we exploited Consensual Qualitative Research with two assessors and one auditor. The compassionate imagery was used to evoke the inner critic, protector and compassionate voice. The results showed differences in the imageries based on the level of self-criticism. Both high and low self-critics displayed difficulties in overcoming their self-criticism. Contrary to high self-critics, low self-critics showed more constructive and positive strategies for dealing with their self-criticism. Our study presented several different patterns between high and low self-critical participants in self-critical, self-compassionate, and self-protective imagery which could be used for diagnostic purposes in the future.

Keywords

Consensual Qualitative Research, Guided Imagery, Self-Compassion, Self-Criticism; Self-Protection

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read and approved the final manuscript.

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Introduction

The way in which people speak with themselves, known as inner speech, has an enormous impact on their well-being, and mental and physical health (e.g., Zessin, Dickhauser, & Garbade, 2015) and on their responsiveness to medical as well as psychological treatment (Shahar et al., 2012; Shahar et al., 2015). Inner speech can take the form of cruel self-critical inner speech, which is one of the key risk factors for different kinds of psychopathology (e.g., Falconer, King, & Brewin, 2015) while self-compassionate inner speech works as an antidote to self-critical speech (e.g., 2010). Recently, the ability to have self-protective inner speech has also been revealed as an important factor in dealing with self-criticism (e.g., Timulak, 2015).

Self-criticism

Iancu, Bodner, and Ben-Zion (2015) define self-criticism as an adverse inner voice which attacks and judges one's own thoughts, emotions, appearance, performance, moods, and

acts. By contributing to negative self-evaluation (Longe et al., 2010) self-criticism is considered to have a negative influence on everyday life (Crăciun, 2013; Duarte, Pinto-Gueiva, & Ferreira, 2014) and on various forms of psychopathology and many other difficulties, such as depression (Gilbert & Procter, 2006), eating disorders (Duarte, Ferreira, & Pinto-Gouveia, 2016), and pain perception (Hooley, Fox, Wang, & Kwashie, 2018; Rudich, Lerman, Gurevich, Weksler & Shahar, 2008). Zuroff, Sadikaj, Kelly, and Leybman (2015) showed that self-criticism is a stable personality trait as well as a stable internal state. Self-criticism is believed to be linked to hostility, contempt or even hatred towards self and inability to produce warmth and reassurance towards self (Whelton & Greenberg, 2005).

Self-compassion

As various definitions of compassion do not differentiate between compassion toward self and compassion towards others, both can be defined as consisting of the following five elements (Strauss et al., 2016, p. 19):

> (1) Recognizing suffering; (2) Understanding the universality of suffering in human experience; (3) Feeling empathy for the person suffering and connecting with the distress (emotional resonance); (4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g., distress, anger, fear) so remaining open to and accepting of the person suffering; and (5) Motivation to act/acting to alleviate suffering.

Marshall and colleagues (2015) stated that being self-compassionate does not automatically mean the absence of negative thoughts or life events, but it helps people to better cope with them.

Self-protection

The ability to be self-protective is allied to the ability to express anger in a constructive or protective way. Protective anger (also known as assertive anger or constructive anger) helps to respond unmet needs and empower oneself to set boundaries as a response to mistreatment (Timulak & Pascual-Leone, 2014). Pascual-Leone and Greenberg (2007) note that the poorer self-evaluation, the harder it is to generate protective anger. They also indicate that being able to generate protective anger is not just about putting aside something that is harmful, but mainly about setting boundaries and standing up for one's rights. Diamond, Shahar, Sabo & Tsivieli (2016) also talk about Emotion-focused therapy theory and believe that protective anger, compassion and sadness are adaptive emotions which help to articulate and work to meet unmet needs. Paivio and Pascual-Leone (2010) found that anger (along with contempt and disgust) is only adaptive when it is external as a response to the violation of one's safety of integrity, but it is problematic if directed internally.

Previous research on self-compassionate/compassionate imagery

Previous research indicates that a person's ability to generate compassionate and self-compassionate images depends on their level of self-criticism (Gilbert, 2010; Gilbert & Irons, 2004). Irons, Gilbert, Baldwin, Baccus, & Palmer (2006) state that if a person recalls parents as warm and caring, his/her ability to generate self-soothing memories will be less difficult. On the contrary, self-critical people do not have access to soothing and reassuring memories and thus recalling these kinds of memories can be rather complicated (Gilbert & Irons, 2004).

Imagery task showed significant differences in the ability to recall the self-critical and self-compassionate parts of self, depending on the person's level of self-criticism (Gilbert, 2010). As shown, high-self critics found it easy to imagine the self-critical and self-attacking part of self, but the self-compassionate part of self was difficult to recall. On the contrary, low self-critics struggled with the self-critical part, but they could easily recall self-compassionate images (Gilbert, 2010).

Imagery is very common technique used in research exploring the effects of self-compassionate and self-critical voices on human lives and health. The aim of self-compassionate imagery is to create an image of a compassionate other, be it human or non-human (Leighton & Halifax, 2003), to promote a positive, soothing state of mind and to help coping with stressful situations (Singer, 2006). This kind of imagery helps to develop the experience of inner warmth and soothing by experiencing compassion towards oneself. Self-compassion imagery is considered to be very helpful for self-critical people (Gilbert & Procter, 2006). Kelly, Zuroff, Foa, & Gilbert, (2010) also suggest that the ability to activate compassionate visualization makes compassionate intervention more effective. According to Rockliff, Gilbert, McEwan, Lightman, and Glover (2008), compassion-focused imagery had an impact on the affective soothing system of people, while more self-critical ones can benefit more from such intervention. Imagery is often used in compassionate and self-compassionate interventions as a tool to cultivate this inner compassionate voice (e.g., Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Neff, 2003; Rockliff et al., 2008).

Previous research on differences between low and high self-critical people

The level of a person's self-criticism and self-compassion appears to have influence on many aspects of their lives whether it is within a clinical or nonclinical population. For example, low self-critics have lower tendency to social comparing and self-rumination (Neff & Vonk, 2009) and they are less anxious and depressed (Arimitsu & Hoffman, 2015) compared to high self-critics; this increase the overall quality of their life (Duarte, Ferreira, Trindade, & Pinto-Gouveia, 2015). Neff, Kirkpatrick and Rude (2007) found that low self-critics show higher levels of well-being, and lower levels of self-criticism, rumination and anxiety. On the contrary, high self-critics are more prone to anxiety, depression, and stress (Gilbert, McEwan, Matos, & Rivis, 2011). It also appears that the level of self-criticism influences interpersonal relationships. Neff and Brevetas (2013) demonstrated that high self-critics often feel isolated and separated from a partner, but low self-critics are rather accepting, autonomous and caring. Allen, Barton, and Stevenson (2015) add that in comparison with low-self-critics, high self-critics struggle to maintain positive attitudes during a relationship crisis. Some studies show physiological differences between high and low-self-critics. According to Rockliff et al., (2008), low self-critics are characterized by increased heart rate variability, lower levels of the stress hormone (cortisol) and reduced pituitary activity. They note that all of these indicators are connected with relaxation and calmness. However, high self-critics displayed the opposite tendencies - reduced heart rate variability, higher cortisol levels and increased pituitary gland activity. Gilbert and Procter (2006) explain that heart rate variability also depends on whether people can trust others, and because high self-critics often perceive relationships as threatening, they might have a hard time feeling compassion, which affects their heart rate variability.

Since being low or high self-critical can have a profound effect on our overall health and well-being, it is striking that, to the best of to our knowledge, no research study has explored how high and low self-critical people differ in terms of the content of their self-compassionate and self-critical imagery. In addition, the use of qualitative analysis is rather scarce in the field of self-compassion and self-criticism. Furthermore, the newest developments in emotion-focused therapy have revealed that it is also significant to include self-protective

imagery into the exploration (Pascual-Leone & Greenberg, 2007; Timulak & Pascual-Leone, 2014).

The qualitative perspective on the topic of self-criticism, self-protection and self-compassion might enrich the current state of the related research area with the knowledge about not only how the inner parts differ from each other in immediate experience, but also how people relate to them and how they overcome self-criticism based on their level of self-criticism. From a wider perspective, the qualitative analysis might provide deeper insight to this topic and so contribute to better planning and delivering various kinds of treatments for healing high self-critics by using good practices of low self-critics for dealing with their self-critic. Consequently, by influencing the level of self-criticism health care professionals can improve mental health of broad population as previous findings showed that even 14 days online interventions can lower the level of self-criticism (e.g., Halamová, 2018; Halamová, Kanovský, Varšová, & Kupeli, 2018).

Aim

The goal of our qualitative study was to categorise participants' descriptions of the content of their self-critical, self-compassionate, and self-protective imagery and to identify differences between high self-critical and low self-critical participants.

Methods

Research team

There were three members of the research team. Two assessors were two postgraduate students with previous experience in qualitative analysis. The third member of the team was the auditor, the associate professor at the corresponding university with extensive experience in qualitative research. All members of the research team were Slovaks, psychologists, and women with the training in Emotion-focused therapy and Compassion focused therapy. In terms of psychological orientation: Jana Koróniová primarily works in the area of qualitative analysis and physiological measurement of compassionate interventions. This study was part of her doctorate thesis. Martina Baránková primarily works in the area of qualitative analysis of compassion and facial expression of compassion. Júlia Halamová primarily works in the area of qualitative and quantitative research of self-compassion and self-criticism. All of the authors and team members are part of the bigger research team working in the area of self-compassion and self-criticism. Two assessors had written down their expectations about the data before they viewed and analysed the data. This is one of the recommended steps to set biases aside, overcome them and be more objective (Hill, Thompson, & Williams, 1997).

Sample

Previous research findings suggest that young people tend to be more self-critical, than older people (Hwang, Kim, Yang & Yang, 2016; O'Connor & Noyce, 2008). Therefore, we considered the sample of university students to be suitable for introspection of their own experience of the three parts of self (self-critical, self-protective and self-compassionate). Participants were recruited among university students who were interested in earning extra credits. All participants provided their written informed consent. The sample consisted of 88 participants (82 women and 6 men; mean age 21.6, SD 1.55). As we were interested in the differences between high and low self-critical participants, we selected a sample of 10

participants (8 women and 2 men) from the very bottom (5) and the very top in terms of self-criticism (5). The mean age of this sample was 21.7 (SD 1.26).

Procedure

The study was approved by the university ethics committee. All of the procedures performed in the studies involving human participants complied with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments and comparable ethical standards.

Firstly, the imagery of the self-compassionate, self-protective and self-critical parts was conducted. Secondly, participants were asked to fill out an online questionnaire immediately after the imagery. The online questionnaire consisted of open-ended questions about the content of their self-compassionate, self-protective and self-critical parts during the imagery and a self-rating scale measuring self-criticism.

For each part we asked the same two questions: 1. Please, describe in as much detail as possible your self-critical/self-protective/self-compassionate part which you have just imagined (How did it look? What exactly did it tell you? How did it tell you that?); 2. Please, write in as much detail as possible about your inner experience when you imagined your self-critical/self-protective/self-compassionate part (How did you feel? What did you think? What were you doing? What behavioural tendencies did you find in yourself? What did you need then?).

Guided imagery

The guided imagery was audiotaped in order to achieve standardized instruction. The imagery took 10 minutes and the participant was alone with a research instructor who was present in the room to switch the audio recording on and off. It started with 30 seconds relaxation instructions and a 30-second pause for the relaxation exercise itself. This was followed by self-critical, self-protective and self-compassionate imagery. Each part was comprised of instructions and imagination in silence. After each set of instructions, there was a 30-second pause to let the participants imagine the particular component.

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (Gilbert, Clarke, Hempel, Miles, & Irons, 2004) consists of 22 self-reporting statements which measure the diverse ways people think about themselves when life doesn't go their way. They comprise three subscales: Inadequate self, Hated self and Reassured self. Inadequate self (9 items) reflects feelings of failure and defeat, while Hated self (5 items) refers to contempt and disgust towards self. On the other hand, Reassured self (7 items) captures positive attitude, feelings of love and acceptance towards self even in situations involving failure. The scale showed good psychometric properties internationally (Halamová et al., 2018) as well as in the Slovak sample (Halamová & Kanovský, 2017; Halamová, Kanovský, & Pacúchová 2017).

Participants´ quantitative selection for further qualitative analysis

We calculated the self-criticism score for the entire sample of 88 participants by summing up Inadequate self and Hated self (FSCRS) by using norms created for the Slovak population (Halamová, Kanovský, & Pacúchová 2017). To capture the extremes between high and low self-critical participants we decided to sort out 5 percent of the most self-critical

participants (42 score, 99.1 percentile) and the least self-critical participants (9 score, 12 percentile). According to previous FSCRS cross-cultural research, these two subscales can be merged to identify the general level of self-criticism (Halamová et al., 2018).

Consensual Qualitative Research

The Consensual Qualitative Research - CQR (Hill, Thompson, & Williams, 1997) method was used for the analysis of qualitative data because of its benefits: taking multiple perspectives and avoiding subjective distortions in analysis, data are categorized by very few people and after achieving a consensus on the categories, data categorization is discussed with the auditor and changes are implemented in the final categorization after group discussions.

Determining thematic areas. The core team for creating categories from the data consisted of two assessors. Each assessor received raw data in the form of the participants' responses to the abovementioned questions about their three inner voices. The responses were categorized for all voices separately and for the high and low self-critical participants distinctly. The participants answered questions about all three parts - self-critical, self-compassionate and self-protective after the imagery. Each member of the team categorized the data separately before discussing categorization within the core team. After arriving at a consensus on the domains, subdomains, categories, subcategories and characteristics, the assessors submitted their categorization to the auditor.

Audit. The auditor checked the first draft of data categorized in domains, subdomains, categories, subcategories and characteristics achieved by the consensus of the two core team members and provided feedback to the assessors. The auditor's comments were considered and implemented in the final version of categorization after the group discussion.

Results

After the completion of the consensual qualitative research of the 2 assessors and 1 auditor, there were 237 assertions altogether. All the coded statements were divided into 61 domains and 30 subdomains. We conducted 23 domains for the self-critical part, 18 domains for the self-protective part and 21 domains for the self-compassionate part of self. In the case of subdomains, the self-critical part was the most numerous (16 subdomains), followed by the self-protective part (11 subdomains) and the self-compassionate part (3 subdomains).

From the analysed data six major domains, valid for all parts of self in imagery task, arose. Domain of Emotions contained all the content connected to emotions, feelings or sensations either by naming them directly or describing them indirectly e.g., by stating a metaphor. Appearance matched all the content about physical looks or even unspecific shape from visual point of view. The domain of Voice addressed the quality of vocal tone specific for the concrete part of self in imagery. Cognitions are related to any kind of thoughts, rational and mental representations. The domain of Needs corresponded to participants´ desires, urges, wants or needs when imagining inner critic, protective and compassionate voice. Behaviour represented the active tendencies resulting from imagery. Whole list of the domains, subdomains, examples of participants´ statements and our explanation can be found below. Consensual qualitative research showed that some domains and subdomains were the same for high self-critical and low self-critical participants and some were different. We also marked in Table 1 that categories that "general" applied to all cases (darker grey), "typical" applied to at least half of the cases (lighter grey), and "variant" (unshaded) applied to at least one case (Hill et al., 1997).

Table 1. *Common and different domains for the self-critical part*

High self-critics	Low self-critics
Emotions	
Sadness (1+2)	
Fear of social assessment (1+2)	
Shame (2)	*Disappointment (1)*
Helplessness (4)	*Anger (2)*
Fear (5)	*Uncomfortable feeling (5)*
Appearance	
Physical appearance (4+1)	
Critic looks like me (3+1)	
Critic looks like somebody else (1)	
Physical impression (9+1)	
Giant critic (4)	Mild critic (1)
Superiority of critic (5)	Difficulties describing the critic (1)
Mercilessness (1)	
Voice	
Raised tone of voice (2+1)	
Cognitions	
Accusations from critic (7+8)	
Self-accusations (6+8)	
Low self-esteem (3)	**Agreement with critic (5)**
Worthlessness (5)	
Incompetence (2)	
Needs	
Need to stop critic (5+2)	
Need for consolation (5+2)	
Behaviour	
	Listening to the critic (2)
	Recalling memories with the critic (2)

Note. The general categories apply to all cases (the darker grey). The typical categories apply to at least half of the cases (the lighter grey). The variable categories apply to at least one case (unshaded).

As we can see in Table 1, regardless of the level of self-criticism there were common domains for both groups. The 6 main domains were: Emotions, Appearance, Voice, Cognitions, Needs, and Behaviour, as mentioned above.

In the domain of Emotions, both groups agreed that they felt Sad ("It made me feel sad…kind of dejected.") about imagining their critical voice, they felt inhibited and disappointed by the comments of self-critical part, and Fear of social assessment ("…that no one will like me with this look"), connected to assessment of others for their imperfections mentioned by self-critic. In the case of Emotions, we can also clearly see that high self-critics felt mainly Shame ("I felt that I had no value and I wanted to be invisible...hide somewhere"), under the influence of self-critic, high self-critics felt tendency to hide because their behaviour or self was assessed by critic as inappropriate, Helplessness ("I started to feel more and more helpless"), the feeling that they have no capacity to help themselves from the attacking critic, and Fear ("When he was attacking me I was scared") stemming from the critics' attack and end in anticipation of suffering. Low-self-critics talked about Disappointment ("…that I cannot handle everything that I would like to and that I disappointed myself") from the fact that they are not perfect and have limited capacities, Anger ("I started to feel more and more angry listening to the critic's accusations") manifested by readiness for a reply to the critic in the same manner, and the rather nonspecific Uncomfortable feeling ("I am not sure what I felt, but it was unpleasant") accompanied by unpleasant physical sensations.

Appearance was another domain. Physical appearance of critic was perceived by minority of high self-critics as Critic looks like somebody else ("I was imagining him as a tall, older man dressed in black") who was out of their own body. Most of the high and low self-critics perceived that Critic looks like me ("He was a perfect version of myself") in various different ways of themselves. Both groups reported that their critic had a typical Physical impression, which varied in both groups. Compared to low self-critics who reported seeing their critic as Mild ("My inner critic was quite mild") and therefore not so invasive and hurtful, or had Difficulties describing the critic ("He was rather of an abstract nature...") when participant wanted to describe appearance of critic, but he was too abstract, high self-critics reported that critic mirrored a Physical Impression, more specifically. Critic looked Giant ("My critic was a giant, standing over me") what points to the size of the critic, Superior ("He was talking to me with absolute power"), that critic was higher in multiple aspect than the participant, Merciless ("My critic was merciless") what points on movement and tune of the critic.

Both groups agreed that critic had a Raised tone of voice ("His voice was raised"), critic voice was perceived like different from the usual conversational tone of voice.

In the field of Cognitions, both groups agreed that critic imagery led to Accusations from critic ("He criticised me for everything I've done wrong in my life"), as critic was talking, participants reflected him as a separate part of self, Self-accusations ("I was criticizing myself for the way I look"), when participants talks about himself as a critic, or Agreement with critic ("…but on the other hand I believed him. When he said I am not good enough I believed him") As we can see, high self-critics compared to low self-critics also slipped to Low self-esteem ("I need higher self-esteem") thinking about qualities they may need to face the critic, Worthlessness ("I have no value...I mean nothing.") when participants think about their meaning as a person, when someone is challenging them, and Incompetence ("He reminded me of how incompetent I was and that things would never go my way"), when critics accusations lead to thinking about their own incompetence and weaknesses.

In the domain of Needs, both groups showed Need to stop critics ("I needed to leave on a quiet place, be there in the present and not listen to anything or anyone"), participants clearly expressed their needs in the moment of critic speech including to say no or in other way stop the critic from criticising, and Need for consolation ("I needed somebody to console me and

assure me that everything was going to be ok") which addressed participants' need to be assured by other close person after the critics accusation.

In the group of low self-critics in domain Behaviour, critic imagery led to Listening to the critic ("I was listening quietly") when criticising lead just to listening, and Recalling memories with the critic ("I was recalling all the situations with the critic involved"), when participants reflecting all the memories that include their critic

Table 2. *Common and different domains for self-protective part*

High self-critics	Low self-critics
Emotions	
Hurt (1)	*Discomfort (1)*
Relief (2)	
Confusion (1)	
Appearance	
Physical impression (2+1)	
Worse version of myself (1)	Kinder version of myself (1)
Difficulties imagining protector (1)	
Physical appearance (1+2)	
Friend (1)	Family (2)
Voice	
Calm tone of voice (1+2)	
Strict tone of voice (1)	
Cognitions	
Reminding what should protector be (8+8)	
I don't believe protector (5)	*Effort to believe (2)*
Needs	
Support (2+2)	
Need to stand up for oneself (2)	
Behaviour	
Empowerment for change (1+4)	
Collapse (4)	
Acceptance by others (3)	

Note. General categories apply to all cases (the darker grey). Typical categories apply to at least half of the cases (the lighter grey). Variant categories apply to at least one case (without underlying colouring).

As we can see from table 2, in the field of Emotions high self-critics felt Hurt ("I guess I wanted to cry, because this is not the way I talk to myself. I was sad to see how a great difference does it make") when it was clear that protective voice can stop the critic a protect her/himself, Relief ("It felt like to be at home…safe and sound") as the self was protected from the critical voice and criticism eased, and Confusion ("I felt confused…I had no idea what is happening") when one reflected, how fast and automatic is sometimes critical reaction and what can the new protective formulation cause. Low self-critics described their emotions rather vaguely mainly as Discomfort ("It felt uncomfortable, because I am not someone who need to be stand up for"), when they realized the protective voice, because for them it can be something automatic and natural in the case of criticism.

The Physical impression in the domain Appearance in high self-critics tended toward Worse version of (my)self ("He looked like me, but smaller…and more scared"), when image of protective self was small and not equivalent to the critical part of self and Difficulties with imagining protector ("It was somebody I did not know"), what sounds like a metaphor for the unknown protective part of the self, which is slight against critical part. Low self-critics had a tendency to see their protector as a Kinder version of themselves ("He looked like me but kinder"), what reflects, that low self-critics have known this part before and recognized this part as the better and kinder self. Physical appearance of protective self for high self-critics was mainly their Friend ("I imagined my good friend...she is tall, confident and beautiful"), what points out that they imagined their protector as an existing person close to them with attributes that might be missing in their own self, while low self-critics spoke about Family ("It is like when your mom comes to take away the pain") with completely different description of the qualities the members of the family brings to them to feel protected.

The quality of Voice was for both groups Calm ("He was talking to me in a calm way…it was rather relaxing"), now we can picture the protector with the kind and calm tone of voice while high self-critics perceived the voice of the protector as rather Strict ("He was talking in a strict way") which can be connected to the novelty of protective voice, which may try to argue with the critical voice.

On the Cognitive level, both groups agreed on Remaining what the protector should be ("The protector said I should not give up and I'm not the only one who makes mistakes") what reminds the participants how to treat themselves in the time of criticism. High self-critics reported that "I don't believe protector" ("I did not support my protector because I'm sure my critic is right"), in this point, participants were sure that it is not clever to protect themselves, because critic is right and possibly they deserve punishment. Low self-critics made Effort to believe the protector ("I inclined to my protector more than to critic but I was curious about which one would win"), they leave the way open for the discussion of self-critic and self-protector, not believed in ones right.

The main Need for both groups was the Support ("Protector told me not to give up, because everyone can do a mistake"), they perceived protector as someone who will shore them in tough situations. High self-critics also reported the "Need to stand up for oneself" ("I am not able to defend myself yet...even though I'd really liked to"), participants recognized the need for protection maybe even when they are not able to really protect themselves in that moment.

Both groups associated the protector with Empowerment for change in domain Behaviour ("He motivates me to change what I do not like about myself. I felt energized, full of motivation"), protector caused the increase of the energy to stand up for oneself and change the current situation, but there was only one case for high self-critics while there were four cases for low self-critics. Moreover, high self-critics showed a typical tendency to Collapse ("I just wanted to lay down, give everything up and not do anything") as it is behavioural pattern which prevents change as mentioned in previous point and high self-critics also associated the

protective voice with Acceptance by others ("As she was talking to me I melted, my pain and confusion went away...her support really helped me") but not themselves.

Table 3 Common and different domains for self-compassionate part

High self-critics	Low self-critics
Emotions	
Relief (4+4)	
	Compassion (1)
	Love towards self (1)
Appearance	
Physical impression (1+1)	
Perfect version of myself (1)	Real version of myself (1)
People (1)	
Family (1)	
Voice	
Kind tone of voice (1+1)	
Cognitions	
Reminding of what compassion should be (7+6)	
Inability to imagine compassion (2)	*Difficulties with compassion (4)*
	Focus on the future (1)
Needs	
Need to be more confident (1)	*Support (5)*
Need for proximity (1)	*Need to escape (2)*
Behaviour	
Empowerment for change (1+5)	
Rejection of compassion (5)	

Note. General categories apply to all cases (the darker grey). Typical categories apply to at least half of the cases (the lighter grey). Variant categories apply to at least one case (without underlying colouring).

In Table 3, there are common and different domains for self-compassionate part. Relief ("I felt everything is ok now and I needed nothing") was the only common domain of Emotions for both groups, participants perceived the compassionate voice as soothing and calming. Apart from that, low self-critics felt Compassion ("First I felt like somebody who is compassionate"), what reflects the intention of the imagery task, but participants really stated to felt that way, and Love towards self ("I started to love myself more and have a better attitude towards myself"), which was another warm feeling while imaging compassionate voice.

When imagining the Appearance of the self-compassionate part of self, low self-critics mainly imagined themselves in a "Real version of myself" ("It looked like me") they were

aware of the fact that compassionate self is a part of themselves, while high self-critics saw a "Perfect version of myself" ("I imagined myself but in a braver version…") which could be unattainable and therefore frustrating. Also, one of the high self-critics mentioned that imagining self-compassion reminded her of her grandmother Family ("the voice reminded me of my grandma...") what is the good sign, if one could feel the essence of compassion firstly in close person if not in his/her own self.

Both groups agreed that the quality of voice was Kind for the self-compassionate part ("The voice was very kind"), in the contrast with previous imagery tasks with self-critical and self-protective voice, self-compassionate voice was perceived only as kind and calming.

On a cognitive level, both groups could Remind themselves of what compassion should be ("He was telling me that it does not matter what happened, because tomorrow will be better and me is all that matters") even if participants didn't feel the compassion, they thinking about the components of compassion. Low self-critics had Difficulties with compassion ("I could not imagine the voice of give it concrete shape") in terms of describing it, for them, even thinking about compassion was hard imaginable, while high self-critics were Unable to imagine compassion ("I felt really odd. On the one hand I really wanted to personalize the voice…but all I heard was the voice of the critic") imagination of compassionate voice was somehow inhibited, for example by the overwhelming critical voice. Low self-critics also reported that imagining self-compassion made them Focus on the future. ("I was thinking that I want to left all the negative behind and focus on the better future") thinking about actual situation lead the participants to consider how they want to be treated in the future, even by their own.

While high self-critics Needs where those of Confidence ("All I needed was to be more confident") to gain strong to stand up for oneself and Proximity ("I needed to be sure that there is somebody out there to help me and give me a hug"), this need was connected to also to the presence of another human being, not to the part of self., Low self-critics mainly mentioned Support (He was supporting me in a way not to be disappointed by myself, because everyone makes a mistake sometimes"), this voice was, for some individuals, also supportive similarly to protective voice. Surprisingly, one participant also found the compassionate voice uncomfortable at some point, and he/she perceived the Need to escape ("I wanted to shut the voice down"), in times, when someone is not comfort with compassionate voice, it may be unbearable.

Both groups, but mainly low self-critics and only one high self-critic perceived compassion as Empowerment for change ("I felt empowered and energized"), in low self-critics, there was a free way to internalize the compassionate voice and work with it. The compassionate imagery made high self-critics Reject compassion ("I did not want to hear the voice, because I did not deserve it"), for this group of participants, to stand compassionate voice was hard, event to listen to this voice was uncomfortable.

Discussion

Our qualitative study aimed to categorise participants' descriptions of the content of their self-critical, self-compassionate, and self-protective imagery and to identify differences between high self-critical and low self-critical participants for the further use in intervention development, counselling and psychotherapy. As self-criticism is considered to be the major underlying factor of all sorts of psychopathology (Falconer et al., 2015) it is very important to explore the differing ways how people deal with own self-criticism and how they overcome it. Equally central for risk of psychopathology is a deficit in the ability to be self-compassionate and self-protective (Pascual-Leone & Greenberg, 2007) as the deficit in these abilities leave people enable to overcome their self-criticism and hence, they end up collapsing. Therefore, our research study focuses on deeper understanding how high and low self-critical people differ

and so enables to refine various kinds of treatments by using good practices of low self-critics for dealing with their self-critic for healing high self-critics. Consequently, by influencing the level of self-criticism one can improve mental health of broad population as there are previous findings that even 14 days online interventions can lower the level (e.g., Halamová, Kanovský, Varšová, & Kupeli, 2018).

As to the advantages of the used research methodology, we agree with Tinsley (1997) that the CQR method is an attempt to combine the flexibility of qualitative research with some accuracy and replicability of quantitative research. CQR makes it possible to capture the tiniest nuances of the phenomenon under examination and puts them into context with other parts of the phenomenon under investigation, and also allows the development of this phenomenon to be captured. The advantage is also the specificity of individual categories, which reflect the liveliness of the studied phenomenon. Another positive aspect is that the reader can, together with the researcher, witness an inductive process, and if the researcher communicates the research output to the reader, it can monitor the reliability of each category. Some limitation of this research methodology. CQR, is also an emphasis on finding common elements and general categories. While, as Rosenwald (1988) said, a deeper understanding of the more complex and complex phenomenon can be achieved by studying the unique characteristics of each case, assuming that each participant can experience a different aspect of the phenomenon. It recalls the situation when several blind people feel some part of an elephant and give different descriptions of this elephant. We will get a better understanding of this animal by synthesizing the lessons learned and not by looking for common overlapping elements of their description.

The main limitation of this research is the written form of data acquisition, which enabled us to obtain more nuclear information and without the need to overwrite it. On the other hand, we got to the data, which was inevitably more concise and, to some extent, truncated and impoverished. Most people say much more than they write. Consequently, immediate interviews after or even during the imagery itself would probably have produced more authentic and vivid data. Also, we did not further detect if our participants had previous experiences on compassionate or any other kind of imagery. Possibly, the results might vary due to level of mental imagery ability. Level of mental imagery ability could affect participants' concentration on the imagery and the way in which they imagined and reflected on the different parts of the self. A poor mental imagery ability could have meant the imagery was of little benefit to some of the participants (Naismith, Mwale, & Feigenbaum, 2017). Although the research was anonymous and participants should feel free to describe their inner parts of self authentically, social desirability might occur and therefore influence their answers.

Extension of methodologies used could provide more relevant and ampler findings. We also recommend the reduction of inner parts imagery. Imagery of three parts of self, and therefore crossing from inner critic to inner protector and self-compassion in a short period of time could be perplexing and might cause difficulties in imagery and difficulties in later description of the three parts as some participants might have problems distinguishing between them.

In addition, the research team's experience, its members' psychotherapeutic trainings and theoretical orientation must be included in the constraints, which has certainly influenced the way data is created by particular imagery instructions, specific questions being asked after the imagery, the way data were handled and worked with. We tried to overcome it by explicitly writing our expectations before handling the data.

Our results brought new findings in this not enough explored research area. Both groups low and high self-critics agreed on rather wide range of areas they were criticizing themselves for. However, high self-critics showed more pathological tendencies across the categories such as incompetence, worthlessness, helplessness or shame. These results are consistent with EFT theory. Greenberg (2004) said that feelings of worthlessness and incompetence are very often

present in lives of high self-critics and these feelings do not change under different circumstances and these feelings tend to recast into feelings of hopelessness, helplessness and shame, because a person cannot understand and use these feelings adaptively. In other words, change and replace negative and maladaptive emotions with more positive and adaptive ones. Timulak and Pascual-Leone (2014) explained, that these negative tendencies stem from so called emotional core pain that refer to specific past unmet and unresolved needs of a client. Also, our study showed differences between low and high self-critics in their ability to elicit assertive anger as a response to harsh critical inner voice. While low self-critics felt angry and disturbed by their inner critic, high self-critics were not able to generate any kind of anger as a reaction to maltreatment and set any boundaries in order to stop the critic which is similar to results of Whelton and Greenberg (2005). Pascual-Leone, Gilles, Singh, and Andereescu, (2013) explained, that highly self-critical people often feel and experience anger but not in an adaptive way. Instead of using the anger as a reaction to maltreatment they tend to aim the anger (along with contempt) to themselves and in most serious scenarios this anger is visible in terms of self-hate. It is in line with Whelton and Greenberg (2005) reporting that high self-critical people have difficulties in generating protective anger. Also, according to the Emotion-focused therapy approach (Pascual-Leone & Greenberg, 2007; Timulak, 2015), self-criticism should be dealt with by evoking and expressing protective anger as well as self-compassion. In our research, low self-critical people seemed to naturally do it even when they were asked to imagine their self-critic, and during the following imagery they evoked and expressed compassion for themselves and protective anger towards the critic. Similarly, emotion of anger in low self-critics might imply a tendency to be protective and stand up for oneself (Pascual-Leone & Greenberg, 2007; Whelton & Greenberg, 2005). As stated by Whelton and Greenberg (2005), using assertive anger is an adaptive way to stop the mistreatment by the critical voice and set boundaries. Timulak (2015) also says that protective anger refers to a healthy way to access and validate unmet needs. Inability to stand for oneself and use assertive anger is visible also in protective voice imagery, where high self-critics had a hard time to seize the voice and when they did, they were not able to believe it. Pascual-Leone and Greenberg (2007) explained that being able to produce protective anger goes hand in hand with a positive evaluation, but high self-critical people often have quite negative self-judgement. Negative self-judgement and the inability to stand up for oneself might be a key aspect when it comes to the self-protector in high self-critics. The same effect was visible in self-compassion. High self-critics had a hard time to even generate the compassionate voice and materialize it. And if they would produce some self-compassionate part, they did not believe it anyway. Gilbert & Irons (2004) mentioned, that the ability to be compassionate towards self is often underdeveloped, because people struggling with self-criticism have often no memories of being cared for or treated with compassion. And on the top of that, they are fearful of compassion and self-compassion (Gilbert et al., 2011) which could be the reason for which our high self-critical participants refused compassion even though some of them were able to produce bits of it. We found out that both groups of participants talked about *Emotions*, but the subdomains were different. Gilbert and Procter (2006) also stated that emotions like shame or fear are associated with high self-criticism and self-critical people perceive themselves as flawed, damaged or even bad.

Qualitative research on compassion and self-compassion conducted by Egan and colleagues (2018) on health care professionals showed, that model of compassion consisted of four major domains. The first called "Keeping it real" referred to compassion as something innate, which need to be authentic to be consider as real. Domain of "Compassion takes time" meant that there are barriers to compassion, which could possibly make it more difficult to feel. The third domain called "There is no time to think about myself" represented the difficulties connected to give compassion to oneself. The final domain "Does anybody care?" addressed the difficulties in getting compassion from somebody else. Our data also displayed participants'

difficulties with being self-compassionate and believing it which correspond to the first, the second and the third domain of Egan et al. (2018). As we did not deal with receiving compassion form others, there is no overlap with the fourth domain of Egan et al. (2018).

Another qualitative study by Baránková, Halamová, and Koróniová (2019) also showed, that compassion cannot be reduced just to one of two aspects. The study implies, that compassion can be perceived on the field of emotions as a mixture of sadness, fear and remorse, but it is also related to empathy. Compassion was also connected to specific behaviour such as support, help or closeness, but there is an emphasis on evaluation. In other words—whether the person deserves compassion or not. The findings are consistent with our study, where mainly high self-critics reported not to deserve compassion, but this tendency was partially also present in low self-critics. The study also mainly supported the findings of Emotion-focused therapy (Greenberg, 2004) about the necessity to face the self-critic with not only self-compassion but also with protective anger and that emotions can be transformed by different emotions. Our study also supported the findings of Compassion-focused therapy (Gilbert, 2010) about the difficulties of high self-critics in generating compassion as they lacked positive memories from their past. According to Johnson and Greenberg (1987), people can create new affiliative memories by transforming their maladaptive emotional responses. Emotions can be transformed to reach more adaptive responses (Greenberg, 2004).

Our sample was quite small, so it is debatable, if and in what extent are our results generalizable. Our results might contribute to knowledge acquired so far in the field of self-criticism and self-compassion and it can be used in creation of effective interventions to reduce self-criticism and increase self-compassion. Also, expanding the knowledge how self-criticism, self-protection and self-compassion works individually and how they relate to each other has the potential to improve work with high self-critics in therapy sessions, counselling or any kind of treatment. The found differences between low and high self-critical people could be exploited for screening or diagnostic purposes in practice as well as in research.

Although many studies deal with self-compassion and self-criticism using quantitative methods there is still lack of studies using the qualitative approach. We know from previous research that self-criticism tends to be present in the case of various psychopathologies (Gilbert & Procter, 2006; Rudich et al., 2008). Therefore, the way people talk to themselves on a daily basis seems to have a huge impact on their physical and mental health and well-being. However, we do not know specifically how people deal with these inner parts of self on a daily basis, whether it is a self-critical, self-protective of self-compassionate voice. Further research should be extent not only to open-question questionnaire, but also to interview or focus groups or in-depth interviews with the relevant individuals. In addition, it would be necessary to involve clinical samples in the analysis in future research. This future research might shed more light on the concept of self-criticism and self-compassion and contribute to creating new and more effective interventions and improving existing ones (e.g., Kirby, 2017).

To conclude, our study showed some distinctive patterns in imagery between both low and high self-critical participants. Facing their self-critic, low self-critics reported accusations from the critic, self-accusations, and agreement with critic, however, they ended up feeling only nonspecific uncomfortable feelings. In comparison, high self-critics allied their self-critic to accusations from the critic, self-accusations, and agreement with the critic, despite the fact that, their critic seemed giant and superior to them and they ended up with helplessness, fear and worthlessness, and the urgent need for consolation. For self-protective imagery, low self-critics reminded themselves of what protector should be and they ended up empowered for change. On the contrary, although high self-critics associated their self-protector with reminding themselves of what the protector should be, they did not believe their protector and ended up in collapse and searching at least for acceptance from others. For self-compassionate imagery, although low self-critics retold themselves about what compassion should be and they

perceived difficulties in imagining their self-compassion, they ended up supported and empowered for change. High self-critics also allied their self-compassionate part by reminding themselves of what compassion should be, but they only felt slight relief and ultimately rejected compassion.

In our study, we were surprised by finding out that low self-critical people actually do not differ so much from high self-critical people in the way how they criticise themselves, they mainly differ from them in the way how they deal with the self-criticism. As if even young people have enough of critical experiences to know how to criticise themselves effectively. Also, surprising finding is that even low self-critical people need to remind themselves what self-protective part and self-compassionate part should do for them to overcome the self-criticism. And that for them it is difficult to believe their self-compassionate part and that they need to put effort to believe their self-protective part too. So, it seems that people need to learn how to deal with own self-criticism and that it is not at all such a smooth process that would be unconscious without being aware of it and without putting extra energy into it.

Our study presented several different patterns between high and low self-critical participants in self-critical, self-compassionate, and self-protective imagery which could be used for planning and delivering various kinds of treatment and for diagnostic purposes in the future.

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