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Working with Self-Hatred and Suicidality in Addiction Psychotherapy[1]

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I was recently invited to consult on a case in which a severely depressed patient was wrestling with chronic and unremitting feelings of suicidality and hopelessness. This deep pain was intertwined with her drug and alcohol use and, despite numerous experiences with different forms of addiction treatment, mental health treatment, and self-help groups, the patient unable to achieve even a year of continuous abstinence or sobriety. The depression remained unabated – whether substances were being used or not. This case again brought home for me Andrew Tatarsky's (2002) key insight that addictions and problematic substance use are complex problems and that "Complex problems require complex solutions."

There are two core ideas that can serve to anchor our engagement with patients like this one. Building on work by Wurmser (1978), the first is that we need to be proceed on two levels. That is, we need to not only work horizontally – which includes those interventions that are specifically focused on the substance use, but also vertically – which includes those interventions that are centered on healing or ameliorating the underlying pain, suffering, and psychopathology. The second is that it is very useful to understand and work with patients using a model of personal multiplicity – which means that we will always seek to understand the patient as an individual containing various parts, modes, voices, or selves.

I have been very influenced by the Schema Mode Therapy model of Dr. Jeffrey Young (Young, Klosko, & Weishaar, 2003). In this approach, we can conceptualize the individual as containing different modes. Here, I will look at four of them. The first is the Inner Leader or Healthy Adult Mode whose tasks include modulating internal forces, engaging in various forms of internal self-soothing and self-affirmation, communicating effectively and assertively with others, and acting in the world in a manner that is purposeful, meaningful, and successful. This mode is often quite weak or underdeveloped in patients who are wrestling with problematic substance use and the overarching goal of all psychotherapy is to strengthen and empower the Inner Leader mode.

The second mode is the Inner Critic – which has also been called the Superego. If all goes well, this mode would be a kind of advisor that seeks to keep the patient safe and helps them live a life of moral creativity; unfortunately, this is seldom the case. In psychotherapy settings, it is not uncommon to find this mode playing a highly oppressive role. The third mode is that of the

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suffering and vulnerable part. The Inner Critic attacks and the Vulnerable Mode suffers. This is where the experience of depression, anxiety, and other forms of self-hatred are experienced. The Coping Modes are fourth. These are basically states where people seek to reduce the suffering of the Vulnerable Mode by engaging in behaviors around Self-Stimulation (shopping, gambling, certain kinds of sexual activity, and risk-taking) and Self-Soothing (alcohol, drugs, food, and other forms of sexual activity). The pain they are seeking to assuage may be from external sources, but in cases like this one, it is often a response to the attacks of the Inner Critic. To be clear, all people rely on Coping Modes; however, when the Healthy Adult mode is weak or insufficient to the task, there may be an excessive reliance on these coping strategies. Putting all of this together, I would hypothesize that a strong experience of self-hatred and inner attack is not only driving the depression and the suicidal ideation in these patients, but also the problematic substance use. To be clear, all of this may be amplified and made more complex when there is also a history of trauma or chronic mistreatment.

In my clinical work, I place a central emphasis on dialogical engagements with the various modes. Using Chairwork as a core therapeutic method, I begin by having a series of conversations and explorations with the Inner Critic. To be clear, I would first seek to ascertain the status of the patient's suicidal ideation. If they are in any kind of imminent danger, it would be imperative to take the steps necessary to make sure that they are in a safe and healing place until the crisis has been successfully managed.

Assuming that the patient is capable of engaging in therapy, I would begin by asking him or her to sit in a chair and give voice to their Inner Critic. In my experience, patients find this to be quite easy to do as that mode is always present. It is my hope to get a better sense of who the Critic is, where it comes from, what its desires and intentions are, and, consequently, how it feels about the patient. Critics usually fall into one of two camps. Most critical voices reflect a part that is, in fact, quite worried about the patient. They are attacking the patient because they are frightened, and they want the patient to do the "right thing" so that nothing bad will happen. The other group of patients have an Inner Critic that is quite destructive. The mode hates them, wants to destroy them, and, at times, seeks their death. This voice may be the internalization of abusive and cruel figures from the individual's past. The first step in the process is to make a kind of differential diagnosis concerning the nature of the Critic.

The next step is to engage with the content of the Critic's attack. As Freud (1969) pointed out, the Superego is irrational – it is not connected to reality. This is true for many Critic Modes as well. Concerning those that are more frightened, it is again important to clarify their values and goals. What do they really want? Why is this important? How will it help the patient? They can then be asked, given this intention – how is the project working? Typically, they will say that it has been a complete failure and that the patient has not done anything that they have requested. At this point, I will usually point out that while the Critic fundamentally means well, their efforts are counterproductive – their criticisms are not only causing depression, anxiety, and problematic substance use, but also making it even less likely that the patient will achieve the Critic's goals. I will then engage with the Critic about taking on a new role – that of advisor.

In a situation where the Critic is more lethal, I use a different strategy. Here I invite and encourage the Critic to be as clear and forceful as possible about how much they hate the patient, the reasons why, and the intensity with which they want to hurt and destroy the patient. I will then argue that the patient should not listen to this mode because the Critic is not on the patient's side, not the patient's friend, and, in fact, is trying to harm them.

In either case, I will, at some point, take a *Defense Attorney-stance* (de Oliveira, 2016) and argue on behalf of the patient. This will include affirming their good qualities, putting their mistakes and failings in a broader context, and championing their decision to live a new and better life. In Schema Therapy, this is seen as a form of *Re-Parenting*. Again, many patients have a weak Inner Leader, and they are not able to mount this kind of exploration and defense on their own. A related issue is that many of them, in part or in whole, actually believe that the Inner Critic is correct – which amplifies their suffering.

It is certainly not uncommon for patients with both addiction and self-hatred issues to report that they have already been in treatment or therapy and that it did not work. I believe that the reason for this is that very few patients have actually engaged in a process in which the therapist specifically and relentlessly took on the Critic, a process in which the therapist engaged with it in a vital and direct manner, week in and week out, until there was a change. Critics are deeply entrenched, and this is always going to be a journey. Again, to my knowledge, few addiction-focused clinicians are working in this manner. I also believe that there is a dose effect to this work and that high levels of therapist intensity may be necessary to facilitate an internal reorganization.

The next phase of the process would be to have the Inner Leader of the patient engage in a dialogue with Inner Critic. I often guide the patient when they go into this mode and help them create an assertive and rooted voice. Some of the basic points to be made are: (1) You have caused me a great deal of pain and suffering and I want this to come to an end; (2) This is my life and not yours – I am in charge and I do not work for you; and (3) I want us to have a new relationship (if the Critic is frightened) or I am now rejecting you and what you are saying because you are not on my side (if the Critic is destructive). Again, this will be a process that may take several sessions.

In recent years, I have become increasingly impressed with the work of Dr. Kristen Neff on Self-Compassion (Neff, 2011). Dr. Christopher Germer (2009), another compassion-focused therapist, defined Self-Compassion as "Giving the same kindness to ourselves that we would give to others". I like to work with patients to create a new Self-Compassion Mode that speaks to the patient with both love and admiration for their successes and good qualities, and resonant empathy for their failures and sufferings.

In some cases, the patients are not currently using substances. With patients who are, I would first explore the nature and pattern of their use. I would then engage in an exploration about the basic nature of the project. Given that the intent is to challenge the Inner Critic and strengthen the Inner Leader, which pattern of substance use best serves that goal? Some may choose to

cease their use of drugs while others may wish to engage in substance use management and switch substances, decrease the dose, and/or change the frequency or occasions in which they use them. We would then develop strategies and skills to implement this plan.

I would like to tell those who are enduring this kind of pain and suffering that these complex treatments are readily available; unfortunately, they are not. However, more and more practitioners are beginning to embrace these approaches and methods. Hopefully, the day will come soon when therapies that bring healing and freedom will be available to all who seek them.

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