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Psychotherapy in Light of Internal Multiplicity

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The view that the self has multiple parts and that these appear in people seeking psychotherapy—and people conducting psychotherapy—is shared by clinicians of various orientations and supported by psychological research. It is useful for clinicians to think of patients as multifaceted and pay attention to the changes between facets that occur during therapy. They can thus help hidden parts to surface, facilitate dialogue between parts not in contact with each other, and convince excessively dominant or oppressive parts to make room for other adaptive facets. The authors contributing to this issue of *Journal of Clinical Psychology: In Session* describe, from their different theoretical perspectives, how they deal with patients' and therapists' inner multiplicity in clinical practice. © 2006 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 119–127, 2007.

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Clinicians in multiple disciplines and of diverse orientations converge on the view that the self is not a monolith, but a multifaceted entity. Each person comprises multiple facets or voices, each possessing its own characteristics, expressing different emotions, and taking distinct perspectives on events and social interactions. As the various parts surface, the person acts and feels differently, processing information differently (Tooby & Cosmides, 1992), anticipating different reactions from others (Baldwin & Main, 2001), and displaying new action tendencies and constructions of meaning.

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For example, a young professional man might be competitive and eager to win while interacting with colleagues at work, where he feels self-efficacious, angry when he perceives others as obstacles, triumphant when he succeeds, and sad when he fails. But he might be different at home: tender and protective while playing with his daughter, noticing quickly any distress in her and moved to take care of her and soothe her. He may encounter problems when his competitive facet dominates and suppresses his caretaking facet, when, for instance, he arrives at home angry from a defeat and yells when his daughter tries to claim his attention.

The aim of this issue is to present and illustrate psychotherapies that treat the self as multiple. The authors, representing various schools, discuss how to conduct treatment in line with this assumption. Although the existence of multiple selves may be dramatically apparent in dissociative identity disorder, borderline states, and schizophrenia, we do not, in this issue, deal with such extreme cases, but rather with the ubiquitous phenomenon of multiple facets or aspects of selves as it appears in all patients. We introduce this issue with a brief review of the theoretical and empirical convergence on the idea of internal multiplicity.

Internal Multiplicity: Theory and Research

Internal multiplicity is present, if not always acknowledged, in most systems of psychotherapy. It is expressed in such cognitive-behavioral concepts as automatic or intrusive thoughts and self-talk or self-statements. Self-criticism and self-blaming, for example, are forms of self-to-self relationships in which a harsh part of the self criticizes or blames another part that is submissive or inferior (Gilbert, 2005). Multiplicity is also assumed in such psychodynamic concepts as internal objects and states of mind and in the humanistic focus on contradictory aspects of self and unrealized potentials. Multiple internal voices are central to dialogical accounts of the self (Hermans & Dimaggio, 2004), as therapists try to distinguish from what positions patients speak and to understand what parts of the self are suppressed and prevented from expressing themselves. Multiple I positions are deliberately used in the service of therapy, in the facilitation of reflective thinking, in the analysis of reciprocal role procedures in cognitive analytic therapy (Ryle & Kerr, 2002), in empty chair work and two-chair work in experiential therapies, in archetypal psychology, and in narrative psychotherapy.

The various self-facets receive different names in different language systems. Prominent examples include *characters* (Bruner, 1990), *roles* (Horowitz, 1987), *imagoes* (McAdams, 1996), *sub-personalities* (Rowan, 1990), *sub-selves* (Markus & Nurius, 1986), *positions or I-positions* (Hermans, 2004), *voices* (Stiles, 1999), and *objects or self-objects* (Kohut, 1977; Modell, 1984). Apart from the different terminology, the common concept is that as their conversation unfolds, patients display self-aspects that are different from each other and surface in accordance with variations in their state of consciousness and the flow of social relationships.

That multiple representations of the self and others appear in patients' speech is supported by psychotherapy research. Research on states of mind theory (Horowitz, 1987) suggests that when people narrate a story, subjective experience makes leaps, with each leap signaling that they have entered a different area in which new interpersonal processes operate. Verbal reports may include distinctive thought contents, emotions felt and labeled with words or described in images of bodily feelings, and other aspects of subjective experience that distinguish the states. Case studies illustrate how patients in psychotherapy often shift among states of mind and that each state represents a self facet. In analyses of psychotherapy audio recordings it is possible literally to identify a change in

which of several *internal voices* is speaking during a patient's discourse, indicated by, for example, a change in intonation, in prosody, or in theme (Osatuke, Glick, Gray, Stiles, & Barkham, 2004). Some voices are kept suppressed, but psychotherapy makes it possible for them to surface and express themselves (Greenberg, 2002). Psychotherapy facilitates the access of overmodulated states of mind to consciousness (Horowitz, 1987) or the emergence of a new voice capable of articulating a patient's inner world and problems and possessing a coherent bird's-eye view of the various characters on stage (Dimaggio et al., 2006).

Research using the core conflictual relational theme (Luborsky & Crits-Cristoph, 1990) similarly supports the idea that patients are guided by a range of representations in their relational actions. Whereas healthy people have a relatively large number of different relationship schemas available to them and can apply them flexibly in line with situations (Crits-Christoph, Demorest, Muenz, & Baranackie, 1994), patients' multiplicity appears limited. An increase in relationship models is linked to a reduction in symptoms; when patients are less dominated by a single pattern, they feel better (Crits-Christoph et al., 1999). In supportive expressive therapy for personality disorders, an exclusive focus on one particular type of interpersonal pattern tends to indicate rigidity of a patient's inner relationship world and predicts dropouts (Thormählen, Weinryb, Norén, Vinnars, Bågedhal-Srindlund, & Barber, 2003). Exclusive dominance of one part of the self over all others thus appears problematic, suggesting that an aim of therapy should be to widen patients' attention, to make them aware of parts of the self previously in the shadows.

This impairment in multiplicity, with patients' range of behavior, choices, and actions limited by their small number of interpersonal patterns, may be particularly important in the psychotherapy of patients who have personality disorders. They tend to apply a limited number of interpersonal schemas; they construe others in a stereotyped and rigid way and give others negative roles, such as persecutor, ill-intentioned, indifferent, depriving, refusing, or blaming. Patients who have paranoid personality disorder, for example, appear to flip between representations of the self as ineffective, weak, and inadequate and representations in which the self is hurt and humiliated by incompetent, malicious, and untrustworthy others. They display abrupt shifts during sessions from moments of intense suffering to fits of anger that may be aimed at their therapist (Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007).

Similarly, narcissistic patients display sharply contrasting forms of reactions toward their therapist, such as seeking excessive admiration from the therapist, vacillating between idealizing and devaluing the therapist, feeling criticized by the therapist, and acting mistreated by the therapist (Bradley, Heim & Westen, 2005). Importantly, a clinician's reactions are also likely to change abruptly as the aspect displayed by their patients switches. Therapists of narcissistic patients are likely to have complementary countertransference reactions, such as *I feel used or manipulated by him/her*; *I lose my temper with him/her*; *I talk about him/her with my spouse more than I talk about my other patients*; *I feel I am "walking on eggshells" around him/her, I feel unappreciated by him/her* (Betan, Heim, Conklin, & Westen, 2005).

Healthy self-facets may be hidden by the pathological aspects of patients' personalities. For example, the first narratives of a woman who had paranoid personality disorder represented the self as weak, ineffective, and incapable, vis-a-vis others described as mistrustful, hostile, and abusing . The self's typical response was to become angry and counterattack. After several months of psychotherapy the patient had constructed a new position from which she observed herself, and she noticed how her responses were rigid and stereotyped. She described her aggressive part as "the dour spinster," using the role

she was playing in the play *Ten Little Indians* as a metaphor. From her new position, she questioned her own rigidity; as she wrote in her diary: "Why do I get so much enjoyment out of being DISAGREEABLE, STIFF, AND INFLEXIBLE. Is it that I want others to pay for how I feel? Venting all my dissatisfaction by vomiting it over them?" In the same period she began to construe others as being interesting and friendly, a definition that had previously appeared only fleetingly and then been immediately suppressed by negative images (Salvatore, Nicolò, & Dimaggio, 2005).

Treatment Strategies

Clinicians who recognize the self's multiple aspects may be more empathic with their patients' internal struggles and acute ambivalence. They may exhibit more attunement or responsiveness, thus being more effective as patients present different facets in different sessions or within one session.

Consider the technical point about making reflections in client-centered therapy: How can a therapist offer respect and empathy to a client who speaks with multiple, sometimes opposing voices? Stiles and Glick (2002) suggested that the therapist's attitude toward a client's multiple internal voices can resemble multilateral partiality in family therapy (Boszormenyi-Nagy & Spark, 1973). As respect and empathy are offered to each voice individually, conflicting internal voices can hear and begin to understand each other, a crucial step toward developing internal meaning bridges. On hearing conflicting expressions, a therapist can reflect *one voice at a time*, rather than try to encompass multiple voices in an omnibus reflection. Reflections that address only one voice may facilitate elaboration by the voice that was reflected, or, alternatively, they may stimulate an opposing response from a voice that was not reflected. Either client response may be productive. Trying to encompass multiple voices with one reflection, on the other hand, is likely to lead to confusion, as it is unclear which voice should respond. Accurate empathy can thus be understood as facilitating conversation and hence mutual understanding among the client's internal voices as well as between client and therapist.

One of a therapist's principal objectives is to monitor the therapeutic relationship, as the problems in transference may be different when a new facet emerges (Safran & Muran, 2000). A patient might feel depressed at the beginning of the session, pushing the clinician to help her restore a damaged self-image. The same patient may feel abandoned by the therapist when he relaxes and may attack him with intense anger. Encountering such a new facet may force therapists to adjust their approach midsession. Recognizing that a patient's new facet has led to the rupture can direct therapists to adopt repair strategies. For example, therapists can pay attention to what has changed after an interpretation or a homework suggestion, tailoring interventions to the new part that appears. Failing to attend to such shifts can make the in-session dialogue resemble one between foreigners speaking different languages.

Clinicians can help patients access parts of the self that might be suppressed or warded off. A patient may seem consumed with despair because life is too hard and she has too many problems. But a clinician might simultaneously detect an angry tone in her speech. A sensitive exploration of this anger may lead to the discovery of a part of the self that is seeking care but is constantly suppressed because the patient feels that others will refuse her requests for help. The aim of such a therapy might thus become helping the patient to give full voice to the care-seeking part by, for example, exploring the idea that no one will provide care and developing mature strategies to obtain it. In situations such as this one it is important for therapists to attend to nonverbal signals: posture, tone of

voice, and facial expressions. The suppressed parts may be more likely to appear in a patient's nonverbal behavior and gestures.

When a clinician notices nonverbal behavior that contrasts with a patient's prevailing discourse, it may be valuable to give voice to that facet. A clinician might say: "While you were speaking about your son, I noticed a flash of joy in your eyes, which you did not have previously. I haven't seen you so full of life for some time, and perhaps even you are unaware of this potential." Another way of accessing suppressed self-parts is through role-playing or two-chair work (Greenberg, 2002), in which patients play roles they are not accustomed to, dedicating time and concentration to emotional experiences they usually ignore. Such techniques can stimulate an increased awareness of feelings previously in the background.

Problems seem to arise not because the self has many parts but because communication between the parts is poor. One problem is confusion, as individuals are seemingly driven by contradictory and intense feelings, each leading a different way. Patients may feel disoriented when they encounter ways in which their inner worlds are incoherent. "Who am I," a patient might ask, "a person who is affectionate and devoted to others or an irate egoist incapable of really loving?" Similarly, when there is no dialogue of the various parts of the self, behavior may seem incoherent. Individuals may swing between anger aimed at getting their way, guilt feelings at the idea of harming others, and the idea of not deserving anything. As the positions shift, their actions also change, with the result that none of them is pursued long enough to be effective. A patient who has dependent personality disorder, for instance, may swing between searching for idealized intimacy and refusing the other during a moment in which she feels patronized by the dominant attitude of her partner or of her boss. These changes make interpersonal relationships confused and difficult to manage for the patient and for the patient's partner (both may ask, for complementary reasons, "Is my partner a lovable person or a monster?").

A lack of contact between voices can cause problems on an interpersonal level as well. The others with whom a person interacts will find themselves in difficulty when the person, for no obvious reason, displays self-aspects that are completely different from previous ones. Even therapists may be made uneasy when, after asking desperately for help, patients shift unexpectedly to a position of anger toward them or are contemptuous of them and accuse them of being incompetent. In this case, the therapists' goal can be first to overcome the surprise caused by the patient's unexpected shift from one part of the self to another and then to help the different aspects of the self make contact with each other, by modulating the patient's intense emotions and working toward making self and behavior coherent.

Resonance With Therapists' Internal Mulitiplicty

Psychotherapists may employ the many facets of their own inner scenario in working with their patients. As noted earlier in relation to narcissistic patients, therapists automatically react differently to their contacts with patients' different self-parts.Therapists might feel fine when a patient asks for help but experience difficulty when, some minutes later, the same patient becomes cold and arrogant. Such a change might evoke a shift in therapists from a facet full of self-efficacy to a facet with low self-esteem and poor reaction to being criticized.

It is important clinically as well as theoretically to note that the responsibility for a therapist's inner shifts is not totally the patient's. Interpersonal psychoanalysis (Aron, 1996), to name but one example, emphasizes that therapists take their personal history, attitudes, beliefs, and values to therapy relationships and that these contribute to both the

positive and problematical aspects of forming therapeutic relationships. We find Bromberg's motto (1998) "Who is talking with whom?" valuable in guiding therapeutic actions. During the flow of conversation, clinicians can ask themselves which part of the patient is speaking with which part of the therapist. Is it a child asking for attention from an adult, who, however, frightens it? Is he/she trying to seduce a person, who, in turn, has need of gratification?

The therapeutic relationship is thus a complex dance in which different partners meet, dance together for a while, and move on. Some partners work well, while others are problematic and unwilling to cooperate.

Finally, many psychotherapy systems consider promoting patients' self-reflection as a therapy goal. This goal involves building up a part of the self that then becomes the observer of the other parts acting in a scene. In other words, self-observation is achieved by promoting multiplicity and differentiation in the self. Once patients have developed this new observer position, they can adopt it as a perspective from which to observe their own cast of characters and their often problematic attitudes.

This Issue

In this issue of the *Journal of Clinical Psychology: In Session*, the contributors describe how they deal with multiplicity of the self both in patients and in themselves. They summarize their respective clinical approaches and then describe a case to illustrate how they treat the internally multiple self in psychotherapy—how to help a suppressed part of the self gain a voice or presence, how to help different parts of the self integrate with each other, how to negotiate meanings instead of acting without knowing the other parts, or how to regulate therapeutic relationship when the interplay between facets of therapist and patient change or when the therapeutic alliance breaks. And they show how these actions foster reduction of suffering, creation of new meanings, and adaptation to the social world.

Lysaker and Hermans present the case of a male diagnosed with schizophrenia, whose multiplicity has been suppressed by a few dominant delusional voices, such as "self-as-persecuted-by-unknown-persons" and "self-as-beloved-through-the-television." The authors, working according to a dialogical self-theory of psychotherapy, show how the therapist helped the patient slowly to gain contact with formerly suppressed parts of the self. The therapist worked trying to make the patient aware of his own authorship of his statements and of the emotions he felt that sustained his discourse. After 4 years of such work the patient learned to see himself as actor and to allow previously suppressed parts of himself to be recognized as his own and allowed to be expressed both in the inner discourse and in social conversation. He also understood that his actions had an audience and that others could be hurt by his disturbing behaviors.

Similarly, Nicolò, Carcione, Semerari, and Dimaggio tell the story of a woman in her thirties diagnosed as having narcissistic personality disorder. The therapist helped her get in touch with a suppressed part of herself, self as fragile. Her life history initially seemed dominated by the memory of a critical and despising mother. As a result the patient could not express her fragility and weaknesses; she was arrogant and despising with others perceived as not being perfect. Her self was restricted, and she could not move flexibly in her social world. The therapist managed to avoid or modulate competition during sessions. He first embodied flawed parts, admitting, for example, to ignorance of topics in which the patient was an expert. As a consequence, the patient discovered that she felt a sense of emptiness when others showed their deficiencies. Later she was able to allow the

therapist access to her fragile parts and experienced only a mild degree of shame. At the end of the therapy she had gained in multiplicity and flexibility.

Osatuke, Mosher, Goldsmith, Stiles, Shapiro, Hardy, and Barkham focus on a single session with a 59-year-old woman treated for depression with cognitive-behavioral therapy. During the session, described by the therapist as this patient's most helpful, two internal voices responded in opposing ways to mistreatment the patient had experienced at home. Initially, the therapist aligned exclusively with a rebellious, self-affirming underdog voice. Session progress stalled, however, until the therapist acknowledged the patient's socially responsible, caretaking voice, which had dominated the patients' interpersonal relations and sense of self while remaining interpersonally submissive. Acknowledging the dominant voice while supporting the rebellious underdog helped build a meaning bridge between them, giving them mutual access and permitting more moderate joint action.

Ryle and Fawkes describe the cognitive analytic therapy (CAT) of a 73-year-old anxious and depressed man. At the beginning of the therapy, the patient feared being rejected by his children and felt defenseless in the world, particularly in relation to his mother and brother. A CAT analysis highlighted reciprocal roles characterized as feeling "powerless, weak, and vulnerable" in relation to "powerful and rejecting." The therapist recognized that she felt rejected by the patient's unwillingness to do his part in therapy and noncompletion of the assigned tasks. She felt entrapped in this pattern, fearing criticisms and feeling unable to act, so as not to be despised. With the help of supervision, the therapist pointed the patient toward an aspect of the self that had been previously in the background. The self was described as manipulating in relation to his mother, who was malleable and controlled by the patient. This self-description helped the patient to gain a new understanding of his brother's behavior. Under the façade of contempt he concealed memories of rejection and harsh treatment by his mother. This understanding slowly led the patient to empathize with his brother and reach a new relation with him. Through this process, he gained access to aspects of the self able to contact others and experience positive feelings toward others and the self. Smith and Greenberg present the case of a middle-aged man seen in emotion-focused therapy, at his wife's suggestion, because of uncontrollable anger that was interfering with his relationships. Emotion-focused therapy proposes that spontaneous reorganization of patients' emotion schemes or voices can occur in therapy when the client slows inner processing and reexperiences problematic situations from the perspective of his or her various separate voices, resulting in an updated narrative account. The treatment focused on the patient's unfinished business, which involved anger and sadness toward his deceased father, from whom he had never received love. The therapist guided the patient through the process of two-chair dialogue, in which he was asked to imagine that he and his father were sitting in opposite chairs. The client was asked to enact a dialogue, switching between chairs and speaking from his own and his father's position in turn. In the fourth session, he identified a problematic pattern: one of his internal voices would feel anger, and immediately a different voice would interrupt that anger and express sadness instead. In a key episode during the 12th session, the patient considered whether or not to forgive the father. Initially, he decided he could not forgive, but the dialogue produced a gradual softening in his attitude. After several exchanges the father accepted responsibility for his failure, and, as the dialogue continued, he expressed love for the client. The patient voice was skeptical but then developed some understanding and pity for his father. When the therapist asked the patient whether he could say "good-bye," as a means of obtaining release from the father's influence, the client realized that he could not do so from his hurting voice but that he could do so from his current adult self. When the therapist then guided the client to speak

from the father's chair, the father expressed regret at the love he had missed and took responsibility for his neglect of the client. When the client returned to his own chair, he found that he understood the father's worldview enough to soften and forgive.

Conclusion

Clinicians who use many approaches acknowledge their clients' internal multiplicity. Their techniques for accommodating and responding to it are as varied as the approaches themselves. We suggest that whatever their approach, clinicians can benefit by considering their patients as multifaceted and noticing how the varied facets shine or fade during therapy. Often therapy involves encouraging submerged parts to surface and negotiating with excessively dominant or oppressive parts to make room. Almost always, it involves facilitating dialogue among parts, improving internal communication, giving mutual access to the parts so that they become resources rather than problems.

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