PART I THEORY, EVALUATION, AND FORMULATION

CHAPTER 1

Affect and Affect Phobia in Short-Term Treatment

Chapter Objective

To describe the basic concept of Affect Phobia and its importance for psychotherapy.

Topics Covered

I. What Is an Affect Phobia?
II. Why This Therapy Focuses on Affect
III. The Definition and Classification of Affect
IV. Adaptive versus Maladaptive Forms of Affect
V. The Development and Treatment of Affect Phobias: An Introduction
VI. The Importance of Anxiety Regulation
VII. The Goals of Treatment

I. WHAT IS AN AFFECT PHOBIA?

This model of Short-Term Dynamic Psychotherapy (STDP) is based on the premise that conflicts about our feelings—what we call **Affect Phobias**—underlie most psychologically based disorders.

"External" Phobias

Phobias are a familiar concept to most therapists. People with phobias may fear a wide variety of external stimuli: bridges, spiders, open spaces, heights, or social situations, for example. To minimize anxiety, patients will use various behaviors to avoid them. Because these phobic stimuli are external, the phobias can be thought of as "external" phobias.

"Internal" (Affect) Phobias

Surprisingly, similar patterns can be observed in psychodynamic therapy. After watching many hours of videotape of short-term dynamic psychotherapy, it became clear to Leigh McCullough that what was conceptualized as "psychodynamic conflict" could equally well be viewed in learning theory terms as **Affect Phobia**—a phobia about feelings (McCullough, 1991, 1993,

1994, 1998). Since these phobias concern internal feeling states, she thought of them as "internal" phobias.

Patients Use Defenses to Avoid Affects

Just as someone with a phobia may drive miles out of the way to avoid a bridge, patients often phobically avoid the experience and expression of certain affects (feelings). One patient may avoid grief, another may avoid anger, and a third may avoid closeness. And, like patients with external phobias, patients with Affect Phobias avoid feelings by developing certain avoidant thoughts, feelings, and behaviors—referred to as **defenses** in psychodynamic language. A principal way that avoidant responses—or defenses—help patients avoid conflicted feelings is by keeping the feelings unconscious or outside of awareness. (However, feelings continue to have powerful effects even when they are unconscious. For example, anger, sadness, or tenderness can be building within us long before we realize it.)

Examples of Affect Phobias

A person who is phobic of being **angry or assertive** may instead act defensively by being silent, crying, feeling depressed, acting compliantly—or, when pushed to the limit, losing control and lashing out inappropriately. Because of the Affect Phobia, this person may be unable to respond more adaptively to their feelings of anger or assertion by setting appropriate limits.

If **grief** is the feared feeling, the person may choke back tears, chuckle to lighten up, or become numb and unfeeling rather than sob and get relief. People who are phobic about **tenderness or caring** often act tough, stay busy, or devalue others rather than open to closeness. These are just a few examples of Affect Phobias; there are many ways to defend against adaptive feelings.

To support our position that these many ways of avoiding feared affects lead to most of the problems that we encounter in outpatient psychotherapy, we turn to the subject of affect itself.

II. WHY THIS THERAPY FOCUSES ON AFFECT

Feelings Are Important Signals

Feelings carry extremely important information about people's reactions to life experiences. To dismiss this "feeling information" is to cut off an essential part of the self. Because of the importance that we place on affect, this therapy teaches patients to ask,

"**What** are my feelings telling me?"

Patients should treat all feelings as vital signals—not necessarily to be acted on, but always to be attended to.

Affect Has Received Less Attention Than Cognition

Both the psychodynamic and cognitive traditions have focused heavily on cognitions (thoughts), intellectual insight, and interpretation; there has been relatively little emphasis on the actual **experience** of affect. This is surprising, since so many patients come to therapy with problems of depression and anxiety. Indeed it may be easier to focus on cognitions because they are more consciously available. In this therapy, we attempt to shift the cognitive–affective balance by emphasizing the central and crucial role of the experience of adaptive affect in therapeutic change.

We emphasize that it is not our intent to say, "An affect focus is good, while a cognitive focus is bad." Cognition is, and always will be, a fundamental agent in therapeutic change. Furthermore, many cognitive therapists work effectively with affect (e.g., with the theory of "hot cognitions"), while many psychodynamic therapists help patients **talk about** affect without helping them to **experience** affect.

Of course, a great many patients come to therapy because of problems directly related to affect, such as depression or anxiety. But there are numerous other reasons why therapy should focus on affect.

Affect Is a Primary Motivator

In addition to symptoms such as depression or anxiety, much of the work in therapy focuses on changing patients' **behavior**. According to affect theorist Silvan Tomkins (1962, Vol. 1, pp. 28–87), there are three motivational systems—inner bodily sensations or feelings—that move us to act or spur specific action tendencies:

1. Biological drives (hunger, thirst, sex, etc.).
2. Physical pain.
3. Affects (anger, grief, sadness, excitement, fear, shame, joy, etc.).

As Tomkins pointed out, **affects are the primary motivators of behavior**, because affects amplify or intensify whatever experience they are associated with. Excitement enlivens an experience, whereas fear, shame, or disgust inhibits it. Joy will encourage participation in a task while shame can all too easily thwart it. Even though drives (e.g., hunger, thirst, sex) motivate behavior, affects can be more powerful. Consider, for example, how easily the affect shame can inhibit the sexual drive, or how the affect disgust (about being fat) can lead some individuals to refuse to eat. (See Tomkins, 1984, 1992).

If affect is the fundamental motivational force in human nature, then affect needs to be central in our clinical theory and practice, in order to have a strong impact on changing patients' behavior.

Affective Connections Can Be Changed

Tomkins also pointed out that, unlike drives, affective connections can be changed (1992, pp. 23–27). We cannot change our drives; we need to eat food and drink liquids—and our sexual orientation is fairly well fixed. But we can change what we have learned to feel ashamed or afraid of. We can learn to be proud of ourselves rather than ashamed, to be joyful about social relationships rather than anxiety-ridden, or to be interested in a task rather than angry or disgusted. We can also learn to become less afraid or less ashamed to experience our sorrow, anger, tenderness, or sexual feelings. In addition to the sense of emotional comfort or pain that affects bring, these inner signals also guide, determine, and motivate behaviors. So, to help patients understand, predict, and control behavior, it is essential to understand and alter the affective connections that lead to maladaptive or adaptive responses. **Affective connections that have been "learned" can be unlearned and relearned.**

Of course, "learning" means more than cognitive book learning, declarative knowledge, or intellectual insight. For behavior change, patients must experience procedural learning, or learning by doing. Patients' feelings, thoughts, and behaviors must be grounded in **physically felt, bodily experience**. The goal of this therapy is to give patients visceral affective experiences that will lead to "relearning"or change in maladaptive behaviors.

The fact that affective connections are learned through experience—and can be changed—makes an affect focus particularly useful and powerful for the psychotherapeutic process of changing unwanted behaviors.

Affects Are Difficult to Identify

Although affects are bodily signals that direct people's actions, they are often outside of their awareness (i.e., unconscious). Affects are therefore difficult for both patients and therapists to identify. For example, patients often say that they are unaware of increasing anger, sadness, or tenderness until it suddenly bursts forth. Thus, if inner affective signals are not sought out, brought into consciousness, and attended to, then unseen affective forces will be directing and/or maintaining patients' behaviors. Missing the presence of core motivating affects will mean that crucial therapeutic opportunities for change may be missed.

Affects Are Feared and Avoided

Feelings can often seem difficult to face, bear, or control. Not only do patients have fears of affect and tend to avoid it, but therapists often do as well. Explicitly focusing on affect in therapy can curb both patients' and therapists' tendency to move away from it. A focus on affect can also help to shape training programs to prepare therapist trainees for this extremely challenging endeavor of focusing on feelings.

Affect Has Neurological Primacy

The limbic and midbrain areas evolved before the neocortex and have been preserved relatively intact through evolutionary development. Affect appears to be generated predominantly in the limbic system and midbrain,

whereas language-based thought and the modulation of affect are apparently processed predominantly in the cerebral neocortex. Although affect and cognition eventually become highly interconnected, the possibility that affect may play a more fundamental or preliminary role needs to be taken into account.

Although the limbic and midbrain systems are often devalued as "primitive," they have been preserved so well by evolution precisely because emotional processing is critical to life. A good example of this is the "conditioned fear" response (LeDoux, 1996). For survival, sensory input regarding possible threats needs to be processed as quickly as possible—a job that falls to the limbic system's amygdala. The price of this speed is accuracy: The amygdala may mistake a stick for a snake and initiate the "fight-or-flight" response. The cortex takes a few extra milliseconds to process the information more discriminately, and can inhibit the amygdala's response after the fact if the snake does turn out to be a stick.

By analogy, we can speculate that interventions targeting the experience of affect will have more effect on the limbic and lower brain systems, while interventions targeting cognition will have more effect on the cortex. More purely cognitive (cortical) interventions such as coping skills may be able to inhibit immediate affective (limbic) responses, but to get to the root of the problem will require dealing with the limbic and midbrain systems, where the experience of affect is mediated.

Affect Precedes Language-Based Cognition

Just as affect preceded language-based cognition (thought) in evolution, affect and motivation emerge before language-based cognition in the development of the infant. Although cognition and affect become thoroughly interwoven as development proceeds, affect is present and predominant in the infant at birth and precedes the development of language. Stern (1985, Ch. 4) points out the significance of affective experiences in the development of the "core" self in the infant. Since affects are fundamental forces in motivating the infant and in the development of the sense of self, these profound and early affective learning experiences need to be taken into account in clinical work.

Affect Is Interwoven with Cognition

Because affect and cognition become deeply intertwined during development, both become major motivators of behavior in adulthood. Cognition plays a vital role in guiding, controlling, and selecting affect, and maladaptive cognitions are strong contributors to pathology. In addition, because of the strong relationship between affect and cognition, cognitive interventions are very effective in modifying affect and behavior. However, attending to cognition without also attending to affective experience is ignoring a fundamental motivator of behavior. In addition, we believe that a substantial portion of the effect of cognitive interventions on behavior can be attributed to **the interventions' impact on underlying affect.**

Throughout this book, our emphasis is on affective experience, but we also stress always attending to (1) **maladaptive cognitions** that block affective change, as well as (2) **adaptive cognitions** that help guide, support, and control adaptive affective responses.

Affect Focus Has Research Support

Finally, an increasing body of research and clinical experience shows that systematic pursuit of conflicted feelings relieves patients' suffering. Two clinical trials have demonstrated the efficacy of this therapy with Axis II Cluster C disorders and many Axis I mood disorders (Winston et al., 1991, 1994; Svartberg & Stiles, 2003). In addition, the efficacy of a focus on affect has been demonstrated in a number of process studies (reviewed in McCullough, 1998, 2000).

Summary

Although cognition (thought) has generally received more attention than the experience of affect, this model of STDP focuses on affect, for these reasons:

- Affect is the primary system for motivation and therefore for change.
- Affective connections that have been learned can be unlearned and relearned.
- Affect is not always conscious, and thus can be easy to miss.
- Affect can be difficult to face and bear, and thus is easily sidestepped if it's not addressed systematically.
- Affect emerged before cognition in the process of evolution, and is processed separately and often before cognition in the brain.
- Affect emerges before cognition in the development of the infant.
- Focus on affect has demonstrated effectiveness in two clinical trials of STDP.

III. THE DEFINITION AND CLASSIFICATION OF AFFECT

Problems with Definitions of Emotions

Emotions are intangible and unseen, and thus harder to label than are concrete external objects. There is very poor consistency about words that denote feeling, both in languages worldwide and in writing about emotions. Given the lack of clarity and the enormous variation in definitions of emotion words, we offer below the definitions of feeling, emotion, and affect that we follow in this book.

Definition of Affect

An **affect** is a biologically endowed set of psychological, bodily/physiological, facial, and hormonal responses that motivate us or move us to act. Affects include interest, joy, anger, sorrow, fear, shame, and contempt. These affect labels are not discrete entities, but different families of feelings. For example, the category of fear includes a range of responses, such as worry, anxiety, fright, or terror; similarly, anger includes a range of forms, such as irritation, assertion, or rage.

Although many authors have proposed distinctions between emotion words (e.g., Tomkins, 1962, 1963, 1991, 1992; Basch, 1976; Damasio, 1994, 1999; Frijda, 2001; Lazarus, 1991; Oatley & Jenkins, 1996, Watson & Clark, 1995), the definitions vary widely and are used inconsistently in the literature. For example, Tomkins uses the word **emotion** as a synonym for affect, while other theorists define emotion as including biography or memory combined with affect (e.g., Basch, 1976; Nathanson, 1992). Given the many conflicting definitions, it seems unlikely that any one proposed set of distinctions will prevail. For this reason, we, like Tomkins, generally use the words **affect**, **emotion**, and **feeling** interchangeably.

The Definition of Feeling

The word **feeling** is often not given a formal definition, though many emotion theorists reserve this term for the conscious experience of emotion or affect. In the practice of STDP, the therapist frequently identifies "feelings" that are outside of the patient's conscious awareness, as in this example:

THERAPIST: Your face looks like you're feeling sad right now. What do you think?

PATIENT: Yes, now that you mention it, I am. I hadn't realized it.

Therefore in our clinical practice and in this book, we do not limit the term **feeling** to conscious experience, but also use it to include the preconscious and unconscious experience of affect.

Furthermore, the verb **feel** has a somewhat broader meaning, because people not only can "feel their feelings," but can feel other sensations as well: external sensations, such as texture or movement in space. Because of this, **feeling** can have broader use than **affect** or **emotion**.

Basic Affects

Though the terminology can be confusing, fortunately the basic affect categories are few in number. Although experts debate the fine points of classification, the four most widely agreed-upon affects are:

Sorrow Anger Joy Fear
(Easily remembered as Sad, Mad, Glad, Scared)

The second four most agreed-upon affects are

Excitement Shame Contempt/Disgust Tenderness/Care

Because each of these affect words represents a "family" of closely related feelings, covering a range of intensities, we follow Tomkins in using dual terms for affect families, such as **enjoyment/joy** or **fear/terror.**

Two Groups of Affects

In clinical work, when changing behavior is a main focus, it is helpful to separate these affect families into two groups:

1. **Activating affects** (e.g., anger), moving us to open up, engage, or approach.
2. **Inhibitory affects** (e.g., shame), moving us to close down, withdraw, or avoid.

Most affects fall into one group or the other, but a few (fear and disgust) can both activate and inhibit. The following is a list of the primary affect families, with a list of related affect terms for each one. These affect categories are derived from the work of Tomkins, but have been modified for clinical use.

Activating Affects

The activating affects move us to become energized and initiate action, to approach rather than avoid, to open rather than shut down, to run rather than freeze. Each of these affects can be used in either adaptive or maladaptive ways (see Section IV below). However, this therapy guides patients toward the adaptive, constructive versions of the activating affects. The eight categories of activating affects are as follows:

ANGER/ASSERTION: ANNOYANCE, IRRITATION, IRE, WRATH, FURY, RAGE.

Function: Activation to assert needs, set limits, push back, or stop an undesired action or boundary violation. Note that while Tomkins refers to **anger/rage**, we always refer to **anger** in combination with **assertion** to emphasize the importance of the adaptive expression of anger.

SADNESS/GRIEF: SORROW, WEEPING, CRYING, SOBBING, MOURNING.

Function: Activation to cry, to engage social support, to relieve pain, and to accept the fact of loss. Tomkins calls this category **distress/anguish**. We refer to it as **sadness/grief** to emphasize the major goal in clinical work—"grief work"—and to distinguish it from emotional pain, an inhibitory form of feeling that often involves maladaptive forms of distress or anguish.

FEAR/TERROR: ALARM, FRIGHT, TREPIDATION, PANIC.

Function: Activation to run away. Fear can also inhibit action (as in anxiety), and we discuss this below in the section on inhibitory affects.

ENJOYMENT/JOY: HAPPINESS, CONTENTMENT, TRANQUILITY, CALMNESS, PLEASURE, ACCEPTANCE, MASTERY, PEACE, AWE, WONDER, RAPTURE, GRACE.

Function: To calm and soothe the mind and body and to repeat pleasurable actions. Activation of relaxing muscles and letting go, accepting with equanimity.

INTEREST/EXCITEMENT: ATTRACTION, CURIOSITY, ENTHUSIASM, HOPE, EAGERNESS, EXUBERANCE, ZEST.

Function: Activation of focused attention, approach, or exploratory behaviors.

CLOSENESS/TENDERNESS: CARE, COMPASSION, LOVE, ATTACHMENT, DEVOTION, PRIDE OR JOY IN OTHERS, TRUST, VULNERABILITY.

Function: Activation of nurturant response to others' needs, as well as openness and trust in others. Activation to embrace, touch, hold, and care for others, and to be receptive, open, and vulnerable to them. Because of the importance of attachment and object relations in clinical work, we separate out this blend of Tomkins's positive affects as they are experienced with others: **interest/excitement** (the basis of attraction and romantic love) versus **enjoyment/joy** (the basis of bonding or committed love). Please note that we often use the term **closeness** to refer to the blend of tenderness, care, and trust.

POSITIVE FEELINGS TOWARD THE SELF: SELF-COMPASSION, SELF-CARE, SELF-ESTEEM, [healthy] PRIDE OR JOY IN SELF, SELF-CONFIDENCE, SELF-WORTH.

Function: Like the previous category, this is a blend of Tomkins's basic affects, but this time directed toward the self. The function of positive feelings for the self is the maintenance of positive self-esteem and the protection of the integrity of the self or self-care. Because of the significance of sense-of-self issues to mental health, this category is very important in clinical work.

SEXUAL DESIRE: AROUSAL, AMOROUSNESS, LUST, SEXUAL PASSION.

Function: Activation to engage in sexual behavior. According to Tomkins, this category is technically a drive rather than an affect. It is included here because phobias of sexual feeling are important in clinical work and can be treated in exactly the same manner as affects.

Inhibitory Affects

The inhibitory affects move us to cease action, to withdraw rather than advance, to tighten rather than loosen. They rein us in and modulate our responses. Inhibitory affects can be extremely helpful when used in moderation, but pathology can result when they are used either too much or too little. The five categories of inhibitory affects are as follows:

ANXIETY/PANIC: FEAR/TERROR THAT PARALYZES, APPREHENSION, WORRY, NERVOUSNESS, VIGILANCE, DREAD, HORROR.

Function: Inhibits behaviors that would put the person in danger.

SHAME/HUMILIATION: SELF-CONSCIOUSNESS, EMBARRASSMENT, MORTIFICATION.

Function: Inhibits behavior that is unacceptable to one's sense of self.

GUILT: CULPABILITY, BLAME, SELF-REPROACH.

Function: Inhibits behavior that is unacceptable to a cultural or societal rule or law. According to Tomkins, this is a derivative of shame/humiliation.

EMOTIONAL PAIN/ANGUISH: HURT, UPSET, DEPRESSION, TORMENT, SUFFERING, WOE, AGONY, MISERY.

Function: Inhibits behaviors by causing discomfort or suffering. This is a response we often see in clinical work, but is not a single basic affect. It may be a mix of a number of affects (e.g., distress/anguish, guilt, shame, anger, or fear).

CONTEMPT/DISGUST: DISDAIN, SCORN, REVULSION.

Function: Inhibits closeness to others. Clinically, this affect is most often seen in sexual conflict or trauma. Although for brevity's sake we will not always include it in the list of inhibitory affects, contempt/disgust should be borne in mind when anxiety, shame, and pain do not explain an inhibition.

IV. ADAPTIVE VERSUS MALADAPTIVE EXPRESSION OF AFFECTS

Depending on how an affect is used and its consequences, an affect may be helpful (adaptive) for an individual and the individual's social milieu, or harmful (maladaptive). For example, anger can be well used to set appropriate limits, or it can be misused, as in temper outbursts, road rage, or violence.

Affect Experience versus Expression

In order to judge whether an affect is adaptive or maladaptive, it is helpful to draw a distinction between the inner (intrapsychic) **experience** of the affect and the outer (interpersonal) **expression** of the affect. Often the way an affect is expressed interpersonally determines whether it is adaptive or maladaptive. However, some affects (e.g., crippling shame about the self) can be harmful based primarily on the intensity of the internal experience.

This distinction between adaptive and maladaptive affect may be unfamiliar to many clinicians. However, to do STDP effectively, it is **crucial** to (1) **distinguish adaptive from maladaptive affects**, and (2) **guide patients toward adaptive expression of feelings and actions**.

Adaptive Expression Brings Relief

Adaptive affect is first consciously experienced within the body, then outwardly expressed interpersonally in a cognitively guided, fully controlled way. Adaptive expression of feeling is not explosive. Adaptive expression brings relief, makes things better, and can make relationships closer.

Maladaptive Expression Makes Things Worse

Maladaptive expression of feelings is interpersonally destructive, resulting in worse feelings between people—more distance, frustration, misunderstanding, loneliness and hopelessness. Here are some behavioral clues that almost always suggest maladaptive expression of affect:

- Self-pity, whining, sulking, victim role
- Acting out, uncontrolled behavior
- Thoughtlessness
- Chronic lateness
- Exaggerated enthusiasm
- False peacefulness, sugary sweetness
- Mindless catharsis (temper tantrums, ranting and raving, hysterical sobbing)

Adaptive and Maladaptive Versions of Affects

Both activating and inhibitory feelings can have adaptive and maladaptive versions. Here are some brief examples of adaptive versus maladaptive forms of activating feelings (including inner experience and outer expression):

Activating Affects:	ADAPTIVE	MALADAPTIVE
Grief	**Grief** feels like a relief (resolves and lead to acceptance).	**Depression** feels like hopelessness, despair, futility, self-hate.
Anger	**Anger** gives relief and a solution.	**Aggression** makes things worse.
Care	**Care** brings people closer.	**Need** is addictive and cloying.

Just like activating affects, inhibitory affects can be highly adaptive. We need our anxiety, guilt, and shame to guide us in many helpful ways! Unguided expression of feelings can create havoc. Society could not function effectively if everyone wildly expressed every feeling, want, and need.

Inhibitory affects become problematic when the inhibition is so great that it is paralyzing, or when it is so little that emotional responses are not modulated.

Inhibitory Affects:	ADAPTIVE	MALADAPTIVE
Anxiety	**Anxiety** signals the need to protect self and others (e.g., softening anger expression).	Excessive or traumatic **anxiety** paralyzes, blocking adaptive action.

Shame/Guilt	**Shame and guilt** can lead to genuine healing remorse, making amends.	**Shame and guilt** leading to self-hate, self-loathing, or self-attack.
Emotional Pain	**Emotional pain** helps one avoid or leave hurtful or abusive situations.	**Emotional pain** is suffering and misery without change or relief.
Contempt/Disgust	**Contempt/disgust** is used in healthy outrage.	**Contempt/disgust** is used to inappropriately attack others or the self.

What Constitutes Adaptive Expression Is Culture-Specific

The judgment of what constitutes adaptive expression of feelings is greatly influenced by one's culture, religion, and social milieu. Although the basic affects themselves have been validated cross-culturally (e.g., Ekman, 1984, 1992; Ekman & Davidson, 1994; Izard, 1990), there can be significant cultural variations in how feelings are expressed outwardly. For example, adaptive expression of anger in China may be different from that in the United States. The examples of appropriate affect expression throughout this book are based largely on dominant North American (Western) culture. Therapists should be open to modifying these guidelines according to their patients' particular contexts and cultures, as well as their own.

We address the distinction between adaptive and maladaptive affect throughout the book. In Chapter 2 we discuss how affects can be used defensively, and thus become maladaptive—a distinction we cover in more detail in Chapter 7.

V. THE DEVELOPMENT AND TREATMENT OF AFFECT PHOBIAS: AN INTRODUCTION

Conflicts about Feelings Are Learned

Affect Phobias develop in the process of growing up. Babies do not spring from the womb burdened with inhibition and neurotic conflicts. Infants have a robust capacity to let us know what they want and don't want. They cry when wet, hungry, or tired, and don't stop crying until their often confused parents figure out what is needed. At 10 days of age infants track their mothers' eyes, and within weeks they will reach out arms to caretakers. Two-year-olds vigorously tell us, "No!" Children are naturally curious and enthusiastic about the world, exploring, touching, tasting everything in their path. Parents and other caretakers naturally use inhibitory affects, such as fear, guilt, or shame, to shape their children's behavior:

"Don't ever say you hate anybody!"

"Big girls don't cry."

"Tone it down! You're getting on our nerves!"

Problems develop when excessive inhibition is placed on a child's adaptive activating affects, such as anger, sorrow, or excitement. Children may then become phobic about feeling, and develop in ways that are excessively inhibited. A child may learn that to be loved or to escape punishment, only certain expressions are allowable. By a process of classical conditioning, the adaptive, activating affect can begin to automatically evoke the associated inhibitory affect. Just as Pavlov's dogs would salivate at the sound of the bell, a person who was overly shamed for being assertive or angry as a child will automatically feel shame when assertive or angry feelings arise and start to be felt.

Affect Phobia and Psychodynamic Conflict

Affect Phobias occur when inhibitions (such as shame) cause great distress or are too strong for activating feelings (such as anger/assertion) to be expressed adaptively. Another term that has been used to describe the same situation is **psychodynamic conflict**, which describes how activating and inhibiting affects are intrapsychic forces pushing in opposing directions. (For more on psychodynamic conflict, see Chapter 2.)

Too Little Inhibition Can Cause Phobias about the Self

There are also cases where inhibitions are insufficient. Then one of two types of problems can happen. First, without some degree of inhibition, children become impulsive and have trouble controlling their behavior. Second, because of the problems that impulsivity causes in living, shame will block positive feelings toward the self—or, in other words, Affect Phobias will develop about self-feelings (e.g., shame blocks healthy pride or self-esteem).

PATIENT: I've always been bad. I was such a bad kid. I just lost my temper all the time and drove people crazy. I don't know what is wrong with me.

Anxiety as a Catch-all Term

In a classic phobia, the feared external stimulus evokes anxiety; in an Affect Phobia, the internal stimulus (such as grief) can evoke any of the inhibitory affects: anxiety, guilt, shame, pain, or contempt. Because of the strength of the analogy to classic external phobias, we often use the word **anxiety** as a shorthand or catch-all term for any of the inhibitory affects. Thus we sometimes speak of "feared affect," even though the affect might evoke shame or pain rather than just fear or anxiety. Historically, this is how the term *anxiety* has been used in STDP (see Malan, 1979).

Resolving Affect Phobias

Conceptualizing the conflict over feeling as Affect Phobia is useful, because extensive research and clinical experience in behavior therapy have shown that the technique of **systematic desensitization** (Wolpe, 1958) can successfully treat phobias. Combining this well-tested behavioral tool within a psychodynamic framework has the potential to make treatment both more effective and more time-efficient (see Chapter 2 for further discussion).

Systematic Desensitization

Systematic desensitization includes three main (but not necessarily sequential) steps:

- **Step 1—Exposure:** Facing the feared stimulus.
- **Step 2—Response Prevention:** Discouraging the maladaptive avoidant response.
- **Step 3—Anxiety Regulation:** Decreasing anxiety in both exposure and response prevention.

Earlier "anxiety-provoking" models of short-term therapy (e.g., Davanloo, 1980; Mann, 1973; Sifneos, 1979) intentionally evoked high levels of anxiety during exposure, which is analogous to the behavioral technique of *flooding*.

Anxiety Regulation as Graded Exposure

By contrast, our model uses anxiety regulation to achieve a "systematic" or stepwise desensitization—also known as **graded exposure.** The therapist helps the patient confront the feared stimulus in stepwise fashion, by experiencing successively "closer" encounters at levels of anxiety that the patient can more easily bear. We call this model "anxiety-regulating" because if the patient's anxiety starts to get too high, the therapist uses techniques to reduce the anxiety to adaptive levels. To be successful, each encounter must continue until the patient's anxiety becomes manageable.

Graded Exposure with External Phobias

In the treatment of a typical phobia, there may be many intermediary steps, or there may be just a few. For example, a patient who is afraid of elevators may first be encouraged to think about elevators until he or she can do so with minimal anxiety. Further steps may include looking at an elevator from a safe distance, entering an elevator with the therapist, entering an elevator with the therapist standing outside, and so forth—continuing until the patient can ride the elevator up and down alone repeatedly and without fear.

The key point is that to effectively lessen the degree of phobic anxiety, each level of exposure must continue until the patient's anxiety reaches normal limits. This is because the conditioned phobic response needs to be desensitized or "deconditioned." Experiencing the phobic stimulus (in this case, the elevator) without anxiety or with successively decreasing anxiety helps break the conditioned response between stimulus and inhibitory feeling. However, it is important to note that if the exposure is terminated while the anxiety level is still high, the phobia will not be desensitized; in fact, the link between stimulus and anxiety may be **strengthened or sensitized**, making the phobia more severe.

Exposure, for Desensitizing "Internal Phobias" or Affect Phobias

The same principles that are used with typical external phobias are used to treat internal Affect Phobias. Patients with Affect Phobias are exposed to progressively higher "doses" of the feared affect (anger, grief, tenderness, etc.) in levels that they can bear, until they can experience each level of adaptive feeling with less of the inhibitory feeling (anxiety, guilt, shame, or pain) present.

Desensitization Frees Up Adaptive Affect

Desensitization does **not** mean reducing the adaptive form of the activating affect. Desensitization means using exposure to reduce or regulate inhibitory feelings—that is, freeing up the inner experience of the adaptive feeling by gradually breaking the stranglehold that anxiety, guilt, shame, or pain (the inhibitory feelings) have on the adaptive activating affect.

PATIENT: I used to feel so mortified [shame] if I even began to tear up [sadness]. Now, thank goodness, if something bad happens, I can let myself cry and feel some relief!

Response Prevention to Maintain the Exposure

Patients with typical phobias avoid the feared stimulus, so for exposure to be effective therapists must help patients prevent this maladaptive avoidant response. In a similar way, patients with Affect Phobias use many defensive tactics to avoid conflicted feelings: intellectualization, dissociation, repression, and so on. (Defenses are discussed further in Chapter 2.) For exposure to be effective, these maladaptive responses need to be reduced or eliminated (**response prevention**). We cover many strategies for response prevention in Chapters 5 and 6 on Defense Restructuring.

Anxiety Regulation Prevents Sensitization

As noted above for external phobias, terminating the exposure while the inhibition (e.g., shame or anxiety) is still high runs the risk of increasing the conflict by sensitizing the Affect Phobia. This is a risk in anxiety-provoking therapies, and is one of the reasons why anxiety regulation is so important in this therapy. For more on anxiety regulation vs. anxiety-provoking techniques, please see *Changing Character* (CC), pages 12–18 and 181–185.

VI. THE IMPORTANCE OF ANXIETY REGULATION

Provoking Anxiety Is Inevitable

When STDP is active and efficient, therapists frequently provoke inhibitory affects. As discussed in the preceding section, exposure to conflicted affect provokes anxiety (or guilt, shame, pain, or contempt), but there are also many other points at which these inhibitory affects arise. For example, simply pointing out patients' avoidant behavior (i.e., response prevention, as discussed above) often brings up anxiety or shame.

Anxiety regulation is the key to making this rapid uncovering form of treatment bearable to patients. For that reason, each chapter that focuses on treatment interventions has a special section on anxiety regulation as it pertains to that aspect of the treatment.

Expose, Regulate Anxiety, Repeat

In general, the treatment follows a simple cyclical pattern. Every kind of exposure provokes anxiety, and when a patient's anxiety starts to get too high, the therapist should use anxiety-regulating techniques to explore the fears and help reduce them. Then, as soon as possible, the focus should return to continued exposure.

From exposure and response prevention
↓
to anxiety regulation
↓
back to exposure and response prevention

This process of moving from exposure to anxiety regulation and back to exposure should be repeated again and again to desensitize conflicts until patients can free up healthy affective responses.

Keeping Anxiety within Limits

During exposure to affect, the patient's moment-to-moment experience of the conflict **must be kept within manageable limits**, so that the exposure to the feeling can continue to reduce rather than increase the Affect Phobia.

Anxiety Regulation for Graded Exposure

As long as Affective Experiencing (see Chapter 7), is proceeding (i.e., as long as the patient is proceeding through memories or reflections with bodily sensations that are affect-laden), then there is little need for anxiety regulation. However, whenever it becomes difficult for the patient to continue (e.g., visible distress, feeling overwhelmed, going "dead," etc.), then anxiety regulation is necessary. At this point, the therapist must explore the inhibition (anxiety, guilt, shame, pain) until the patient can more comfortably go back to experiencing the affect. This gentle process of exploring anxieties makes graded exposure to the feelings possible.

The cornerstone of anxiety regulation is to explore the anxiety, using a standard question from cognitive therapy: "What's the hardest [worst, scariest, most painful] thing about _____?" Many examples of patient–therapist dialogue throughout this book will contain some variant of this question, like this one:

THERAPIST: Can you see how you've just pulled away from the joy [or sadness, or anger, or tenderness] that you were feeling here with me?

PATIENT: Yes, now that you mention it . . . I guess I did.

THERAPIST: What is the hardest or most uncomfortable part of that for you? [Anxiety regulation]

PATIENT: I feel so vulnerable [anxiety] when I really let myself go and relax, I can hardly stand it!

THERAPIST: Well, before we go any further, let's talk about what feels so scary about being vulnerable. [More anxiety regulation]

Anxieties Are Never Eliminated

Anxiety regulation does not mean anxiety elimination. As we have explained, people need inhibition to guide and modulate their behavior. They need to know when they might hurt themselves or others. Healthy, cognitively balanced levels of inhibition tell people how to guide their actions without deadening their lives. So some degree of inhibition is always necessary.

Anxiety Regulation for Too Little Inhibition

Most outpatients have more problems with excessive inhibition than they do with insufficient inhibition. However, there will be some patients who act out impulsively and who thus may enter therapy with insufficient inhibition. Such uncontrolled behaviors and underlying feelings may need to be sensitized rather than desensitized. In such cases, the role of anxiety regulation is to increase rather than decrease anxiety. Thrill-seeking individuals may need more anxiety; sociopathic individuals may need more conscious guilt and shame. People who are abused will need to become more sensitized to pain to be more self-protective.

PATIENT: I always had a mean streak. In therapy, I let myself see how I'd hurt a lot of people. I learned to be more sensitive to other people's feelings and I control my tongue better now.

Some Inhibition or Conflict Always Underlies Impulsivity

But, at the same time, these impulse-ridden patients will also need to decrease their anxiety about other painful underlying feelings. As noted above in Section V, insufficient inhibition can lead to Affect Phobias about the self (e.g., shame about the self or poor self-esteem) because of the destructive results of impulsive behaviors. Furthermore, when there is poor self-esteem, other Affect Phobias may occur, such as fears of closeness, inability to grieve or longing for acceptance. Behaviors such as thrill seeking or con games may help to avoid these painful affects. Thus, even when impulses are out of control, there is always some degree of inhibition or conflict present.

PATIENT: I was so mean to so many people that I felt like a really bad person. I felt like I didn't deserve much, and I couldn't trust that people cared for me.

Summary

To summarize, this treatment model uses the following:

1. **Exposure** to stay with the experience of feeling the activating affect.
2. **Response prevention** to maintain exposure by preventing a defensive or avoidant response.
3. **Anxiety regulation** to reduce or modulate anxiety, guilt, shame, or pain linked to the activating affect.

Systematic desensitization is covered in more detail in Chapters 2 and 7.

VII. GOALS OF TREATMENT

Values in Therapy

Every therapy model is unavoidably value-laden, and its goals reflect those values. The keys are (1) to make those values explicit, and (2) to take patients' (possibly conflicting) value systems into account. In this chapter and

throughout the book, we try to make explicit the central values of this therapy model, which include the following:

- Full experiencing and mature expression of feeling (authentic functioning).
- Compassion for self and others.
- A healthy balance of autonomy and interdependence.
- Therapy that is as efficient and effective as possible.

We believe that therapy based on these principles leads to an improvement in both individual and societal functioning. Of course, readers will need to weigh our values against their own and integrate them as they see fit. In addition, therapists must always remain flexible in regard to their patients' personal/cultural/relational contexts, so long as the results continue to be constructive and life-enhancing.

A good guideline for authentic expression of feeling—with profound implications—comes from a Norwegian children's story about an idyllic town called Kardemomme:

> One should not bother or harm others,
> One should be good and kind,
> But otherwise one can do whatever one wishes.
>
> *(Man skal ikke plage andre,*
> *Man skal vaere grei og snill,*
> *Og for ovrig kan man gjore hva man vil.)*
>
> —Egner, 1955, p. 5; translated by Leigh McCullough with help from Ronnaug Leland and Roar Fosse

Authentic Functioning

Thus the goal of this therapy is to enable patients to experience affects fully and manage them intelligently, so that they are capable of adaptive, authentic functioning—but while also taking others into consideration. Affect Phobias prevent authentic functioning by blocking the affect needed to motivate healthy responses. Resolving Affect Phobias achieves this therapeutic goal by freeing up affects to motivate adaptive and interpersonally mindful responses.

Knowing and Practicing Control of Feelings

When people are not conscious of their feelings and not practiced in controlling them, the feelings are much more likely to emerge in hurtful, destructive, or embarrassing ways. Because these conflicted, maladaptive patterns are (at least in part) learned, they can be "unlearned'' and more flexible and adaptive ones can be acquired. This therapy helps patients bring feelings into consciousness, tolerate them, and use them to guide effective action for themselves and in relation to others.

When affects are no longer blocked, there is no longer the phobic avoidance of honest emotional reactions. Rather than having to deny, repress, or "fake" a feeling, patients learn to experience feeling fully (inner experience), and also learn **when** and **how** it is appropriate to respond with behavior (outward expression) to others.

To Modulate, Not Obliterate Feeling

Although we advocate that feelings be cognitively guided and fully controlled, we do not mean that feelings should be squelched or thwarted. Instead, patients are helped first to experience and contain the inner experience of feelings, and then to modulate the outward expression of their feelings to others—without shutting down or obliterating them.

Optimal Balance between Autonomy and Interdependence

In Western societies, especially the United States, people often strive for "independence" and "self-sufficiency"—not needing anything other than what one can provide for oneself. Indeed, the traditional dynamic model defines maturity as autonomy and independence, achieved through the separation/individuation process and internalization of others.

In contrast, a more progressive view is that healthy **attachment** to others, not separation, is the mark of maturity. The need for others is seen as adaptive and legitimate not only in childhood, but throughout the life span. Individuals exist, grow, and develop in relation to others in a dynamic interaction, and need both autonomy and deep connection. Therefore, this therapy model helps patients develop an adaptive balance between autonomy (the ability to meet one's own needs, express what's inside, etc.) and interdependence (the ability to be receptive and responsive to feelings of others, etc.). Interventions for developing these capacities are presented in Chapters 9 and 10.

Desensitizing Affect Phobias Helps Authentic Functioning

Desensitizing Affect Phobias (i.e., resolving psychodynamic conflict) fosters authentic functioning in many ways:

- Conflicted affects become more freely and maturely expressed.
- Conflicted relationships become closer and more gratifying.
- Conflicted feelings about the self become more self-compassionate.

Examples of Authentic Functioning

Think of authentic functioning as living in the moment and responding deeply and genuinely, but always **mindfully** of others. This is exemplified by the ability to experience and express the fullest passion—the firmest, clearest anger; sobbing in grief; rapt attention in enthusiasm; the tranquility of joy—but only if such passion is used **appropriately, constructively**, and for **mature purposes**.

Authentic functioning allows people to respond in the following ways, to name a few:

Inner Affective Experience	Outward Affective Expression
When delight and surprise arise	To laugh with joy.
When waves of sorrow flood the body	To cry with sadness.
When feelings of anger build energy	To speak up and set firm limits.
When something is interesting	To pursue interests with enthusiasm.
When desire and passion arise in the body	To make love openly and freely.
When tender feelings emerge in the heart	To give and receive love wholeheartedly.

When patients have learned how and when to respond to themselves and others in affectively open, honest, and appropriate ways, they have achieved **authentic functioning**. They no longer have Affect Phobias and, in general, no longer need therapy.

CHAPTER 1 • EXERCISES

From this chapter to Chapter 10, we offer exercises at the end of each chapter. Answers can be found at the end of the book in the Appendix. We consider these "answers" to be "strong possibilities." They are not meant to be taken as absolute, and there will be many other equally good (or possibly better) answers.

EXERCISE 1A: IDENTIFY ACTIVATING VERSUS INHIBITING AFFECTS

Directions: Are the following affects activating or inhibiting? In other words, does the affect in question predominantly promote:

- Action/approach/openness/involvement (activation), or
- Restraint/withdrawal/closing off (inhibition)?

Circle the correct answer. (Also, try to think of a rationale for why the affect is either activating or inhibiting, though you need not write this down.)

Exercise 1A.1.	Shame	Activating	Inhibiting
Exercise 1A.2.	Grief	Activating	Inhibiting
Exercise 1A.3.	Healthy pride	Activating	Inhibiting

Exercise 1A.4.	Curiosity	Activating	Inhibiting
Exercise 1A.5.	Guilt	Activating	Inhibiting
Exercise 1A.6.	Self-confidence	Activating	Inhibiting
Exercise 1A.7.	Anxiety	Activating	Inhibiting
Exercise 1A.8.	Justifiable outrage	Activating	Inhibiting

EXERCISE 1B: IDENTIFY THE AFFECT

Directions: For each of the following sentences, choose what you think the speaker's affect is from the affect list in the box below, and indicate whether that affect is activating or inhibiting. More than one affect may be possible.

Affect Selection List:

Anger/assertion	Excitement
Grief	Joy
Tenderness/closeness	Sexual desire
Guilt	Shame

Positive feelings about the self (e.g., pride, self confidence, self-esteem, self-care, etc.)

Example: When I saw that cute little puppy, I just wanted to pet it!

Answer: **Affect?** Tenderness/care **Activating** **Inhibiting**

Exercise 1B.1. By the time I handed in my assignment, I was so pleased with how well it came out.

Affect? _____ **Activating** **Inhibiting**

Exercise 1B.2. I heard about ethnic cleansing in Bosnia on the radio, and I almost started to cry.

Affect? _____ **Activating** **Inhibiting**

Exercise 1B.3. I finally realized I was working too hard, and I just went to bed.

Affect? _____ **Activating** **Inhibiting**

Exercise 1B.4. I told him he'd have to wait his turn.

Affect? _____ **Activating** **Inhibiting**

Exercise 1B.5. I couldn't even look at him, I felt so bad about what I'd done.

Affect? _____ **Activating** **Inhibiting**

EXERCISE 1C: SPOT THE AFFECT PHOBIA

Directions: In each of the following exercises, select one or more of the affects that might be blocked due to Affect Phobia. (Put another way, which affect or affects might the speaker be defending against?) Make your selections from the list of affects in the box above in Exercise 1B.

Example: A girl who loves to tap-dance dances exuberantly, but can only do so with a controlled, expressionless look on her face.

Answer: **Possible blocked affect(s):** Excitement

Explanation: She might be embarrassed to show how enthusiastic she feels. She could also be feeling joy, but afraid or ashamed to show it.

Exercise 1C.1. A man acts concerned and caring with his adolescent daughter, but refuses to give her a hug.

Possible blocked affect(s): _____

Exercise 1C.2. A teacher complains of getting migraines at work with increasing frequency. The principal is treating him unfairly, but he has said nothing.

Possible blocked affect(s): _____

Exercise 1C.3. A married woman finds that when she is with her husband or friends, she is unable to state her needs if they are different from the group's.

Possible blocked affect(s): _____

Exercise 1C.4. A young woman often receives praise for her job performance, but feels that she is secretly a fraud and fears being found out.

Possible blocked affect(s): _____

Exercise 1C.5. A young man says that he has not been able to have a girlfriend for 5 years—ever since he broke up with his fiancée, with whom he is still furious.

Possible blocked affect(s): _____

Exercise 1C.6. A patient who has been steadily improving in therapy sits in her garden noting, for the first time in as long as she can remember, the beauty of the day. Suddenly she feels overwhelmed by anxiety.

Possible blocked affect(s): _____

Exercise 1C.7. A young man is having a panic attack, brought on by his girlfriend's making an off-hand comment about "wanting children someday."

Possible blocked affect(s): _____

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