CHAPTER 7

Creating Change through Focusing on Affect

Affect Phobia Therapy

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Theoretical Introduction

Affect phobia therapy (APT) is an integrative psychodynamic therapy that seeks to help patients function better by resolving emotional conflict through reducing their avoidance of adaptive, activating emotions. The focus on emotion in APT is important for several reasons. According to Fridja (1986), emotions are the means and measure of a person’s engagement with the world. Tomkins (1995) stressed that affects are biological motivating mechanisms that can be understood as having primacy in human agency. Maladaptive use of emotions has therefore been suggested as central to psychopathology (see, e.g., Gross, 1998, 1999; Gross & Muñoz, 1995; Schore, 2003; Southam Gerow & Kendall, 2002). Indeed, Post (2003) stated, “It is not surprising that emotional dysfunction lies at the core of a variety of psychopathological conditions” (p. 899).

The central goal of APT is therefore to help people experience and express their emotions in an adaptive way. Aristotle (as quoted in Leonard, Miles, & Van der Kar, 1944) said that anybody can become angry—but “to be angry at the right person and to the right degree and at the right time.
and for the right purpose and in the right way—that is not within everybody's power and is not easy” (p. 203). Essentially Aristotle was alluding to the idea that affect is important for social relations, an idea that is central to current theory and research on emotion (see, e.g., Fischer & Manstead, 2008).

APT is an integrative model of psychotherapy. The framework originated in psychodynamic theory and important concepts included from this tradition are conflict, defenses, and insight. However, the traditional psychodynamic concept of unconscious conflict between the id and the superego is replaced by a focus on the experience of emotional conflict, based on the theory of Tomkins (1995), and relies on the motivational function of affect. The conflict in APT is conceptualized as the tension between activating and inhibiting affects. The model integrates learning theory when describing how associations between affects are formed, how affects are experienced, and how affects are expressed. In APT, therapeutic change relies on an integration of principles from dynamic therapy (i.e., transference and countertransference, self and object relations), cognitive therapy (utilizing the time between sessions, psychoeducation, testing assumptions), emotion-focused therapy (focusing on and experiencing affect), and behavior therapy (exposure for warded-off affect).

Central to APT is the concept of affect phobia. APT defines an affect phobia as a phobia for experiencing or expressing emotions. Just like people can have phobic reactions to external stimuli—for instance, spiders, needles, or elevators—people can have phobic reactions to internal stimuli, importantly, their feelings. A person with a spider phobia will be fearful when in proximity of spiders and will avoid situations where he or she might come in contact with a spider. Similarly, patients may find various emotions aversive and engage in a variety of strategies to avoid them. The concept of phobias refers to an irrational fear, but APT uses the word phobia in a broader, more metaphorical sense, as APT recognizes that fear is not the only cause of avoidance of certain affects. A person with a phobia against experiencing and expressing anger might feel guilt and anxiety when anger is activated and might try to avoid the discomfort of experiencing this conflict between aggression and guilt by intellectualizing that there was no reason to set limits for him of herself, and he of she might try to avoid situations where setting limits will be important for her (McCullough et al., 2004; McCullough Vaillant, 1997). Although some of the symptoms and consequences of affect phobia may resemble alexithymia, an affect phobia typically is specific to certain feelings and has very specific dynamics involving relationships among feelings.

APT postulates that there are two broad categories of affects: inhibitory affects and activating affects. This distinction stems from the early writings of William James (1890/2011). James postulated that if affect is motivational there must be at least two types of affect: affect that motivates
approach behavior and affect that motivates avoidance. Significantly, in APT one does not separate affects into categories without looking at the function they serve for a person in a specific context. Anger is a prime example. Anger can be maladaptive if it leads to aggression in the workplace, in intimate relations, or when driving a car, or is used to avoid intimacy or grief. As well, anger can be maladaptive if a person aggressively attacks herself, which prevents the person from experiencing positive affects toward herself. But anger can also function as an adaptive activating affect when it motivates the person to set limits with others, to resolve conflicts, and to express displeasure with others’ inappropriate behavior. On the whole, anger, sadness/grief, closeness, and self-compassion tend to be activating and important for the person to experience and express appropriately, whereas anxiety, guilt, shame, emotional pain, disgust, contempt, and fear tend to be inhibitory affects because they tend to inhibit other emotional responses. Typically patients seeking therapy, who do not have problems with impulsivity, will need help to experience more of the activating affects and less of the inhibitory affects (McCullough et al., 2004; McCullough Vaillant, 1997).

An affect phobia is a maladaptive pattern that occurs involuntarily. An activating affect is aroused (e.g., sadness, anger, or joy) and an opposing, inhibitory affect (e.g., anxiety, guilt, shame, pain) is aroused simultaneously. If the inhibiting affect is so strong that it prevents or distorts the experience of the activating affect, the capacity to experience and express the activating adaptive affect becomes inhibited or blocked. It is not uncommon for any one activating affect to have more than one inhibitory affect associated with it. Feelings of guilt and shame might for instance be activated when a person is in a situation where it would be adaptive to experience anger. This conflict between the affects is uncomfortable for the person, and in order to avoid the discomfort the person uses defenses such as intellectualization or repression, or coping strategies such as avoiding situations where the discomfort will be elicited, or by ruminating obsessively. Even though defenses and coping strategies are different phenomena, they function similarly. Defenses tend to be unconscious efforts to ward off conflicted affects, whereas coping strategies often are conscious behaviors to achieve the same goal (Cramer, 1998). The end result is that this maladaptive affect pattern, the affect phobia, prevents the person from experiencing and expressing her natural reactions to events in her life in an adaptive manner. The relationships between activating affects, inhibitory affects, and defenses are summarized in what is referred to as the “triangle of conflict,” one of two triangles in affect phobia that schematically summarizes important concepts in the model (see Figure 7.1; Malan, 1979; Menninger & Holzman, 1958).

The triangle has activating affects at the bottom corner, indicating that these affects are underlying phenomena in affect phobias. These affects...
are aroused, but through experiences the person has learned an association between these affects and inhibitory affects. The right corner of the triangle represents the inhibitory affects. In a well-functioning person the inhibitory affects modulate and adapt the activating affects to fit the situation in which the person finds herself, and the person is able to function well in a variety of situations needed to have a functional life (i.e., does not avoid situations where the conflict may arise). Shame might regulate grief so that a person will not sob while at the store, but allow the grief to come to the surface in the presence of supportive friends. But in an affect phobia the inhibitory reactions associated with the activating affects are too strong. The experience and expression is either strongly reduced or blocked. In order to ward off these conflicted feelings, the person resorts to defenses, represented by the top left corner of the triangle (McCullough et al., 2004; McCullough Vaillant, 1997).

Working with restructuring this maladaptive pattern is one of the treatment objectives of APT. Even if affects are basic motivational processes (Tomkins, 1995), maladaptive emotional patterns are learned, often very early in life (McCullough Vaillant, 1997). A typical example can be a young boy experiencing grief. He is told that men don’t cry and his father shames him every time he feels sad. At the same time he might receive reinforcement from his father every time he is able to suppress his sadness, and consequently he avoids his uncomfortable reactions and seeks his father’s approval by suppressing sadness. The boy learns that shame is associated with grief, and as a grown man the feelings of shame may prevent him from experiencing grief in his current relationships, thus sacrificing the intimacy necessary for close relationships. He is not able to experience and express emotions related to his losses, and might well then avoid situations where grief can be elicited. This pattern may also be present in the interaction with the therapist when the person comes to therapy. This patient’s pattern of developing an affect phobia can be formulated in the second triangle used in APT, the “person triangle” (see Figure 7.2). At the bottom corner is the earlier relationship wherein the phobia originated, at the right corner
is the current relationships wherein the patterns are experienced presently, and at the left corner is the therapist. Understanding the development and function of the maladaptive pattern in this triangle is a second treatment objective in APT. This is sometimes also referred to as “insight into maladaptive patterns” or “insight into defenses” (McCullough et al., 2004; McCullough Vaillant, 1997).

The patient’s sense of self is an important concept in APT, and has implications for how one understands the patient’s affect phobia. The renowned cognitive researchers Neisser and Jopling (1997) described an interpersonal self as an agent in social exchanges. People are co-creators of interactions with other people, and perceive themselves as acting in the real world. Neisser writes that a close match between the intentions and the outcome of a behavior establishes a strong sense of agency and of effectiveness. A person’s sense of self can be understood as the behavioral expressions that he or she thinks are possible in a given situation (Bergner & Holmes, 2000). In affect phobia the self is understood as part of the affective dynamics. In the conflict triangle “self” is written in the middle. If a person can experience and express his or her affects in socially adaptive ways, the person will experience a strong sense of self. If, however, a person feels that he or she cannot tolerate or bear to experience or express affects, the sense of self tends to be weaker. Often one will hear patients with a weaker sense of self express things like “I don’t deserve to ask for anything,” “I have never felt proud of myself,” or “I focus on what other people want; I don’t know what I want for myself.”

People with a stronger sense of self might need shorter treatments. Therapists tend to be able to start with an affect exposure, which is described below, early in treatment. Often these patients have acquired an affect phobia later in life, and treatment focuses on a specific event or on the influence of a particular person (like a demeaning boss). For example, a soldier who was trained to be stoic at age 18 may only need to focus on one specific trauma of military training to resolve symptoms. However, if a patient was repeatedly hit or ridiculed by his father for crying when he
was a child, treatment may be more complex because the affect phobia is more ingrained. The patient might have a harder time with recognizing or experiencing the affects and may become confused by his or her affective experiences. The sense of such a patient is that if he or she experiences the avoided affect he or she would catastrophically disintegrate. Patients with a weaker sense of self might need interventions to help them strengthen this sense of self. These interventions include exposing the patient for feelings of closeness and self-compassion (which are placed at the bottom corner of the conflict triangle along with other activating affects), with the therapist adopting an empathic and accepting stance. In this way the therapist is providing an emotionally corrective experience with regard to the patient’s sense of self. Interventions aimed at the sense of self are interspersed between exposures to warded-off affects to help the patient regulate his or her affective reactions to these distressing emotions.

**Introduction to Therapy**

APT uses the theoretical framework discussed above by helping the person experience and express previously warded-off adaptive, activating affect. The therapist aims at preventing the patient from resorting to defensive behavior, focuses on the activating affect, and helps regulate the inhibitory affect. Throughout this process attention is given to understanding the foundation of the phobia and the function the maladaptive pattern serves. In order to achieve these goals, therapists must be acutely aware of the affects experienced by the patient when talking about important events in the patient’s life. The therapist pays close attention to the facial expressions and bodily movements of the patient, the pitch and tone of the patient’s verbal expression, and how well these responses reflect the content of the verbal report of the patient, and whether or not important details are left out of the verbal report.

A primary characteristic of APT sessions is the elicitation of the adaptive activating affect, which serves as an exposure. Through inhibitory affects and defenses, the patient is unable or unwilling to express an adaptive activating affect. The therapist works to encourage the patient to experience and express the affect in the therapy session, and the therapist emphasizes that the patient can do this without being punished, humiliated, or criticized, as was likely the case for the patient in other circumstances in his or her life. Instead, the therapist will praise the patient for having the courage to express these difficult emotions. This process serves as an exposure, as the patient engages in the avoided behavior (i.e., expressing a particular emotion) in a safe context. Repeated exposures to the adaptive activating affect teaches the patient that the associations between the activating affects and inhibiting affect and defenses can be changed. The affect
exposures typically are repeated several times, with the therapist pointing out the progress the patient is making in experiencing more of the activating affect, less of the inhibitory affect, and less frequent or more mature use of defenses. The exposures are repeated until the patient freely can experience the affects in the session. The exposure process can involve affects that are present when the patient is thinking of situations in his or her life by helping the patient re-experience situations using imagery exposures or by working with affects that are present between the patient and therapist. In order to help the patient experience the affects fully and freely, it is often necessary to help the patient experience affects and express them in ways that would not be possible or socially adaptive outside of the therapy room. After this is accomplished, efforts are made to make sure the patient understands the difference between the therapeutic work in a psychotherapy session and the adaptive expression of affect outside of the therapy room.

Take, for example, a woman coming to therapy after her son committed suicide, presenting with clear symptoms of depression and anxiety. She had a stiff and unmov ing body when talking about the day when her son committed suicide. There were some signs that her eyes were tearing up as she talked about the events that day, but her voice was flat and she talked quickly and in a “matter of fact” kind of way, with little emotional content. She jumped from when her husband came running in to the house screaming that their son was lying dead in the garage to the day she was standing at the son’s grave a week later, after the coffin had been lowered down into the grave. There was clearly avoidance of sadness and grief, and perhaps anger, in her description of the events. The therapist was able to aid the patient by empathically helping her experience the affects she had for these events. The therapist helped her to slow down her pace of talking, allowing her not to rush through the experiences, but to pay attention to what was happening to her as she told the story. The therapist then talked about how affects carry important information and why it is important to pay attention to grief and specifically about how grief worked in the body (i.e., psychoeducation about affect). As the patient was telling the story, the therapist emphatically pointed out when the patient was rushing her words, and when she was avoiding painful material, such as her seeing the dead body in the garage, helping her regulate the intense emotional pain she was experiencing, continuously and empathically orienting her toward the warded-off grief.

When the patient was ready, the therapist proposed an imagery exposure, having the patient imagine being alone with her son while he was lying in the coffin, and being present in the church before the funeral. The patient was able to express, with much emotionality in her voice, face, and body, her feelings of grief, love, and loss to her son, before she was able to say good-bye to him. The therapy then went on to focus on the meaning of loss and her identity as a mother. She expressed that as a child she felt
she was unwanted by her parents. Her emotional reactions were never validated, but were often punished. She felt like she could not express who she was, and the first time she felt joy and a sense of worth in her life was when she could be a mother.

The remainder of this chapter presents research in support of the treatment orientation and interventions used in APT, before moving on to a more detailed description of how APT is conducted.

Evidence in Support of APT

APT utilizes techniques from several approaches to psychotherapy, including cognitive, Gestalt, and learning approaches, but the fundamental framework is psychodynamic. The interventions used in APT therefore have research support from several traditions. APT is typically regarded as a short-term psychodynamic psychotherapy. Shedler (2010) summarized the evidence for the general effect of psychodynamic therapy, whereas Leichsenring, Klein, and Salzer (2014), Leichsenring, Rabung, and Leibing (2004), and Abbass, Hancock, Henderson, and Kisely (2006) found evidence for the efficacy of short-term dynamic therapy for common psychiatric disorders. For personality disorders, Abbass, Sheldon, Gyra, and Kalpin (2008), Winston et al. (1994), McCullough et al. (1991), and Svarterberg, Stiles, and Seltzer (2004) have found evidence supporting the efficacy of short-term dynamic approaches. Research on DSM-IV Axis I disorders and short-term dynamic approaches have found evidence for the effectiveness of these treatments for depression (Bressi, Porcellana, Marinaccio, Nocito, & Magri, 2010; Driessen et al., 2010; Leichsenring, 2001), generalized anxiety disorder (Leichsenring et al., 2009; Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011), anxiety disorders in general (Bressi et al., 2010), and somatic disorders (Abbass, Kisely, & Kroenke, 2009).

APT has in particular been studied in personality disorders with encouraging results. Using a first-generation APT, Winston et al. (1991) studied 32 patients with anxious-avoidant, histrionic, or mixed personality disorders randomly assigned to brief adaptational therapy (BAT) or to APT and then compared the results with a wait-list control. The two active treatment groups showed significant improvement on outcome and were significantly different from the wait-list control at termination of therapy. APT had larger effect sizes than BAT but the difference did not reach significance. In Winston et al. (1994) the previous study was expanded, with a larger sample size ($n = 81$), and the findings were largely replicated. In addition, the study also reported that improvement in target complaints were maintained at follow-up (mean time to follow-up 1.5 years, $n = 38$). Svarterberg et al. (2004) studied 50 patients with anxious and avoidant personality disorders, many of whom also reported comorbidity with Axis I
disorders. The patients were randomly assigned to either cognitive therapy (CT) or the current model of APT. At termination, the patients showed significant improvements on symptoms, interpersonal relations, and personality functioning, and results were similar at 2-year follow-up although there were no significant differences between the two treatments. At 2-year follow up 54% of APT patients had recovered symptomatically, whereas 40% of the CT patients had done the same (Svartberg et al., 2004).

As already mentioned, APT has three treatment objectives: defense restructuring, affect restructuring, and self and other restructuring, all with their respective foundation in research and theory. Diener, Hilsenroth, and Weinberger (2007) found a relationship between therapist facilitation of affect and outcome for psychodynamic psychotherapy. Several studies of dynamic therapy have explored this relationship in more detail. Coady (1991), Hilsenroth, Ackerman, Blagys, Baity, and Mooney (2003) and Jones, Parke, and Pulos (1992) found that patients who had a therapist who focused or oriented the patient toward affect had better outcomes than patients who had therapists who did not focus on affect. McCullough et al. (1991) found that interventions that were followed by an affective response in the patient were associated with a positive outcome, and particular therapist interventions (viz., confrontation, clarification, and support) were important for the patient's affect experiencing (Town, Hardy, McCullough, & Stride, 2011). In fact, Ulvenes et al. (2012) found that avoiding affect was not associated with good outcomes, even if avoiding affect was associated with a good bond, and the bond often is found to be predictive of good outcomes. This finding has been interpreted to imply that within APT focusing on problematic affect is so important that it must be done even if it interferes with the formation of the therapeutic bond because the focus on affect leads to better outcomes, despite the attenuation of the bond. Sometimes it appears that patients know they have to do difficult work even though they would prefer to avoid it (see also Wampold & Kim, 1989).

There is evidence from theoretical orientations that are integrated into the APT model that support various therapeutic actions. Process–outcome research points toward the importance of both deepening and engaging in exploration of emotions (Greenberg, 1984; Greenberg, 1979; Mackay, 1995) and of engaging in imaginal confrontations (Greenberg & Malcolm, 2002; McMain, Goldman, & Greenberg, 1996) for producing good outcomes. However, there is also evidence that purely emotional activation (i.e., catharsis) may not be helpful (Bohart, 1977, 1980), and that an integrated experience of affect, self-narrative, and reflection is superior to only emotional arousal (Elliott, Greenberg, & Lietaer, 2004; Greenberg, Auszra, & Herrmann, 2007; Mergenthaler, 1996; Purton, 2004; Stalikas & Fitzpatrick, 1995; Warwar & Greenberg, 2000), which indicates the importance of working on all three therapeutic objectives in APT: helping the patient experience and express the conflicted affect, understand and reflect on the development and function of the defenses (or maladaptive
behavioral patterns), and see the significance of this work related to the patient’s experience of him- or herself and other people.

**Practical Introduction to Therapy**

To illustrate the process of APT, a transcript based on an American Psychological Association (2012) PsychTHERAPY video recording from a therapy session with Leigh McCullough, the developer of APT, is included below, with descriptions of nonverbal behavior and explanation of the therapist’s intentions. The session is a good illustration of how working with the triangle of conflict is accomplished. There is, however, much happening in the session, including work on the triangle of the person and on the patient’s sense of self and sense of others. Due to space limitations, only a transcript of the beginning of the session is presented to give a sense of how a session can unfold. The material relates specifically to how affect can be worked with in therapy and exemplifies the moment-to-moment tracking of affect as well as the therapist’s effort to help expose the patient to activating affects in session.

The patient is a male in his late 30s. He has a son from an earlier relationship, but does not have much contact with him or his earlier partner. He is planning to get married, and this new relationship is triggering his sadness over being separated from his son. The patient is showing signs of anxiety.

**THERAPIST:** What would you like to focus on?

**PATIENT:** Ah, my son.

The patient is stuttering, trying hard to find words. His body is leaning over to one side, one arm clutching the other. It looks like he is trying to control an activation of his body. He is avoiding eye contact, and his facial expression is similar to one experiencing physical pain. He takes a long break before starting to talk. The therapist infers that the patient is trying hard to manage something inside of himself. As can be seen here, the APT therapist is focused on the nonverbal behavior and its inconsistency with the patient’s verbal report.

**THERAPIST:** Is this hard for you to even talk about?

**PATIENT:** *(Laughs.)* Yes.

The therapist is trying to bring attention to the patient’s activating affect by orienting him toward the difficulty he is experiencing when talking about what is problematic to him. The patient is displaying a defensive reaction. He has learned how to avoid the activating affect, and in an
instant he is laughing while at the same time confirming that it is difficult to talk about his son. Clearly, it is hard for him to talk about what is troubling him.

THERAPIST: You are putting on a big smile.

The therapist is empathically validating the defense, but at the same time mirroring what the therapist hypothesizes to be the avoided activating feeling, a sadness.

THERAPIST: *(gesturing toward her chest)* What's the feeling that's coming up?

PATIENT: *(smiling)* It's rough.

While smiling, the patient confirms that it is difficult for him to be in contact with his problematic emotions.

THERAPIST: If you didn't smile, what would you be feeling?

The therapist is empathically probing for the avoided feeling. The therapist observes that the patient is able to take away the smile for less than a second and that he is thinking about or experiencing something, but the defenses are activated again, and a strong burst of laughter is present.

PATIENT: *(laughing)* Right, right.

The therapist notices that the patient is clutching his arm tighter, looking like he is striving to control himself, but the rest of his body is moving about like he is laughing cheerfully. Paying attention to his eyes and mouth, the therapist is able to infer that sadness is present.

THERAPIST: That smile helps shove it down, doesn't it?

The therapist is again orienting the patient toward the underlying feeling and commenting on the defense.

PATIENT: Hmmmm, hmmm. *(His eyes and mouth suggests sadness.)*

THERAPIST: What has been the hardest?

PATIENT: *(Looks calmer, but not in touch with his feelings.)* With him? You know, we're close you know, we're close. *(Looks a lot calmer, but the smile disappears.)*

THERAPIST: You are close?
PATIENT: (Nods.)

THERAPIST: And you haven’t been able to see him?

The therapist is trying to build momentum for the sadness to come to

the surface.

PATIENT: No, no (shaking his head, looking down, feelings of sadness

more present), not regularly. (He is avoiding eye contact and his voice

is not much affected by sadness, but he is swallowing.)

The therapist interpreted swallowing as a sign of anxiety or inhibition,
as often swallowing is due to a dry mouth.

THERAPIST: Let me just point out, you had a big wave of sadness just now.

The therapist has noticed signs of sadness and points out the underly-
ing but not experienced feeling.

PATIENT: (Looks interested but with a smile on his face.)

THERAPIST: And you pushed it down. Can you feel yourself doing that?

The therapist is helping the patient see that this is something the patient

is doing actively himself, not an automatic process outside of his control.
That is, the therapist is making the unconscious conscious, in a sense.

PATIENT: Sure, sure. It is interesting. Wow. (laughing, and is looking with

affection at the therapist)

THERAPIST: You hadn’t realized. People do these things automatically.
What would it have been like to let that show here with me?

The therapist is simultaneously acknowledging and normalizing the
defenses. She is also using the person triangle by bringing herself, the ther-
pist, into the dynamic of the affects, thus using the transference rela-
tionship therapeutically.

PATIENT: I have no idea (still smiling affectionately). I don’t know (speaking

in a soothing voice).

THERAPIST: Would it have been hard to do that?

The therapist is exploring the inhibitory reactions.

PATIENT: (Looks interested and thoughtful.) Yeah, I think so, I think that

would have been hard.
THERAPIST: Let us look at that because that is what we are here for right now. To look at things that are difficult. You know you have to stuff them down all through the day. It would be a shame to do that here.

PATIENT: It is weird, it is like, it's like it's all concentrated now (pointing to chest, laughing) it is so freaky (hand covering his face while laughing). Whatever the feeling is, whatever the thing is, you know. Now it is a little less, you know, I guess it's because I'm a little more animated. When I started talking a little more it gets less. You know I get to use my hands, and I get to be animated, and I get to forget about it. That's a little strange.

The patient is noticing how his behavior with the therapist is helping him manage and control his affects.

THERAPIST: But you are paying attention to it. That is good, let us pay attention to it, watch it go up and down.

After less than 2 minutes into the therapy session a few things are becoming clear on the triangle of conflict. Initially what was most apparent was the patient's defenses. The affective conflict was so uncomfortable and so ingrained that it was hard to see both the activating feeling and the inhibition associated with it, although the therapist was quite aware that the patient was suppressing the activating feeling of grief, as exhibited by smiling while talking about difficulties with his son. As the therapist continuously helped the patient examine the activating feeling, the patient was able to both identify that he is avoiding some affect, and how he was doing it. He is also able to understand that it is a feeling of pain and of roughness that prevents him from experiencing sadness. Mapping this exchange onto the triangle of conflict, we would have sadness or grief at the bottom corner, pain and maybe other inhibitory affects on the right corner, and defensive reactions like laughing, avoiding eye contact, becoming animated, and the like on the left corner.

THERAPIST: Is there any sadness left right now?

The therapist again is orienting the patient toward the sadness.

THERAPIST: Where do you feel it in your body?
PATIENT: Right here. (pointing toward his heart)
THERAPIST: What is there? (looking empathically at patient)

The therapist is actively using herself as part of the person triangle. She is communicating that the experience of the sadness is understood by
the therapist (empathy) and that this feeling is accepted by the therapist (reinforcement).

PATIENT: What is here? Oh, that is my heart.
THERAPIST: You feel your sadness in your heart.

The therapist is anchoring the affect in the body, and orienting the patient again toward his feelings of sadness. In APT, it is recognized that affects have a bodily felt component, although the patient uses defenses so that it is not "experienced." Thus, the APT therapist will frequently focus on the somatic sensation of affect, and help the patient pay attention to and notice when affects create sensations in the body.

PATIENT: But it is more at the top of my stomach, yeah the same area.
THERAPIST: Is there pain there?

The therapist is trying to identify any inhibitory affects, again using somatic sensations.

PATIENT: Pain?
THERAPIST: Or is it sad?
PATIENT: Not like hurt pain but, probably like, I mean, if I, I would say, the feeling that I had, and since I'm rambling now it is not there. But the feeling that I had was probably thick.
THERAPIST: Thick?
PATIENT: Yeah, strange.
THERAPIST: And it really showed on you, you welled up. And you have a way of, as you say, you are rambling now, you have a lighthearted way of moving, it seems to pull you away from it.

The therapist is commenting on the patient's defenses, but in an empathic manner.

PATIENT: Yes, yes.
THERAPIST: That is something you developed no doubt to stay afloat and stay buoyant.

The therapist is acknowledging the defenses or maladaptive patterns, which were developed sometime in the patient's life. The therapist is also acknowledging that these defenses have helped the patient in his life at some point. It is central in APT, as well as other dynamic therapies, to recognize that defenses are adaptive in some instances or in
some developmental periods, but that they are related to the patient's difficulties in the current situation, a theme that is pursued in the next few interchanges.

PATIENT: Yes.
ThERAPIST: Are you typically very buoyant, like this?
PATIENT: Yes.
ThERAPIST: That is a tremendous strength in life. It gets you through rough times, doesn't it?

The therapist is again validating the defenses, pointing to them as resources the patient has used to good advantage in many instances, but which are causing the patient difficulty in the present circumstance. The therapeutic strategy is therefore to not have the patient defend against the activating feelings, but to block the function of defenses in the session and try to bring the patient into contact with the avoided feeling.

It should be recognized that the goal of APT is not simply to have the patient experience the affect (e.g., grief/sadness in the present situation), but to utilize the affect to respond adaptively. The patient will be making some decisions about how to structure his relationship with his son, given his impending marriage. Decisions will be more adaptive for the patient when he is able to experience and express his grief. The patient will then be basing his decision on a fuller range of his affects that inform the patient what he is feeling about the situation. Because of the motivational function of affects, having access to a fuller range of affects will help the patient be motivated to choose more adaptive behaviors with his relationship to his son. The function of grief can be understood as motivation to help the person reflect and reorganize his life and future after a loss. Experiencing adaptive grief will help other affects and behavioral tendencies to become available and help the patient navigate his circumstances and relationships. Having desensitized the associations between the adaptive, activating affect and the inhibition and defenses, the patient is also better prepared to handle situations in his future where experiencing grief will help him not become anxious or depressed.

In the present case, avoiding feelings of grief and sadness may lead the patient to accept the situation with his son; he would then tolerate not seeing him and being involved in his life. On the other hand, experiencing grief and sadness may motivate the patient to assertively ask his ex-partner for increased visitation rights and to demand that the ex-partner function better as a parent. The patient may determine that if the ex-partner is not adequately parenting the child, he may seek custody. None of these actions is likely without experiencing the loss of his son, as his inhibition has led to inaction and passivity.
PATIENT: I think so.

THERAPIST: But here we need to try to set that aside if we can, and help you touch into this pool of pain you are sitting on. Right, that’s right there. About your son.

PATIENT: (Sadness wells up, visible on the frown his mouth is making and the tightening of his eyebrows.)

After having affirmed the adaptive aspect of the defense, the therapist is directing the patient back again to the activating affect that is being avoided. The therapist is helping the patient identify the feelings that are present and how his pattern of behaving is moving him away from his felt sensations of affect. The therapist has recognized the maladaptive pattern, empathizing with the patient and pointing out how the defense has served a purpose and was developed to help him in various aspects in his life, but that it might not help him in the current situation.

The therapist goes on to explore what inhibitions are present that prevent the experience of affects.

THERAPIST: As I say that, does it come up again?

PATIENT: No, but I am thinking about trying to let it, thinking about, OK, let me put my hands down and open up a little bit, because I’m kind of like closed.

THERAPIST: Right, right, good to notice that. The other thing that I think would help is just to be, let’s just be, for a moment about, what it would be like to let down and open up and show that sadness. Are you able to do that in your life?

The therapist is exploring what inhibitory affects might be present that prevent him from experiencing his activating affects. This is also an attempt to expose the patient to affect. The therapist is checking if the patient is able to let go of his inhibitions and experience the avoided affect freely.

PATIENT: You know, people are eh, people have expectations (smiling) you know, they have expectations and hmm (a slight expression of contempt is visible).

The patient is using another defense here involving what others will think of him. The patient is feeling some expectations put on him from the outside. He believes that he is expected to behave in certain ways, and that these expectations are in conflict with his affective responses. We can infer that violating these expectations will lead to feelings of either shame or guilt and to the discomfort associated with feeling these inhibitory responses are obstructing the experience of sadness.
THERAPIST: What kind of expectations?
PATIENT: That, hmm (looking down, tightening of lips, eyebrows clenched together, almost closed eyes, a facial expression mixing concentration and pain, and now looking up again), I'm not sure, it just feels like it is inappropriate.
THERAPIST: I see, well certainly men in our culture are taught that boys don't cry. Right?
PATIENT: Right.
THERAPIST: But when you say people have expectations, that you are not to have feelings, that you are not to lean, is that it?

The therapist is testing out assumptions connected to the pain that is inhibiting his expression of affect, challenging the defense.

PATIENT: Yeah, well I don't know. I think I'm ... It is hard not to concentrate in the camera now.
THERAPIST: That is all right, you don't have to apologize. Let's take a minute and think about that. This is being videotaped, what does that bring up?

When possible, the APT therapist works on the feelings present in the therapy room. These often occur when talking about troublesome issues, but here the therapeutic context is brought up by the patient, perhaps as a defense, so the therapist works with these feelings, as they are related to the central triangle of conflict.

PATIENT: Guard. There's 10 million people (burst of laughter).
THERAPIST: Ten million people, that is a hard thing. It takes a lot of courage for you to be here, doesn't it?

The therapist is accepting the inhibitory affect, while at the same time reinforcing a strong sense of self, another key component of APT. Here, the therapist hypothesizes that a low sense-of-self is also inhibiting feelings of sadness and therefore attending to the sense-of-self will increase the likelihood that the patient will express the warded-off affect.

THERAPIST: So let's take 1 minute and see what do you think me and the 10 million other people might be thinking?
PATIENT: Ahh, you know (slight pained expression on his face).
THERAPIST: Of you, if you were to let down.

The therapist is again testing assumptions related to the inhibitory feeling.
Affect Phobia Therapy

PATIENT: I don't know, you know, if I think about it for a minute, probably, I'm not sure, I don't think, I'm not sure, you know.

THERAPIST: Well, just let the thoughts come, there is some projection you are doing. You know that term? You project something out thinking there is going to be some way that you are going to be viewed. It makes you put up your guard.

The therapist has identified some thoughts and also some projections that refer to the patient's sense of others. These thoughts and projections interfere with the patient's experience of affects, and the therapist will continue to work on them and reduce their impact on the activating affect.

THERAPIST: So there is something that you are projecting out, I am going to ask you one more time. Let's just see if you can put some words on it. Let's imagine someone watching this session right now.

PATIENT: Pity.

THERAPIST: That they would pity you. And how would that make you feel?

PATIENT: I don't need pity.

THERAPIST: You don't need pity. There is a guard right there. It is a shame response. You'd be ashamed if someone pitied you. If they saw you so sad. As sad as you are in your heart.

The therapist is first pointing out the inhibitory affect, before accentuating that he is not showing the sadness in his heart, as a way of emphasizing the cost of his defenses.

PATIENT: Yeah.

THERAPIST: Well, let me put it this way, if there was a man sitting here (pointing toward an adjacent area, opposite of patient), telling the same story, and he was open and he could really show his sorrow, how would you feel toward him?

PATIENT: I would accept the guy, you know, I would.

THERAPIST: Is it hard for you to think to feel that others might feel that toward you?

The therapist is pointing out that he is not letting himself have the same understanding or compassion toward himself that he would for another. He has different standards for himself than for other people. The therapist is trying to regulate the inhibitory response.

PATIENT: (slight pained expression) I'm not sure. Perhaps you know.
THERAPIST: Perhaps they could feel accepting toward you.
PATIENT: Sure.
THERAPIST: That is hard for you to feel deeply. Is that what you are telling me?
PATIENT: It is hard to wrap my mind around why, . . . why are you guarded, you know, it's not the easiest thing to fit in.

The therapist has identified a feeling of pity and shame that is associated with displaying affect. The inhibitory affect is preventing the expression of affect in the session and in the patient's life in general. There is also an understanding that this is something the patient is putting on himself; he was able to feel acceptance toward someone else telling the same story and opening up. After working with reducing the inhibitory and defensive reactions, the therapist now moves back to try and help the patient experience the sadness associated with his son.

THERAPIST: You were starting to talk about your son and how awful it has been for you.

The therapist is redirecting the patient back toward experiencing the avoided activating feeling.

PATIENT: It's been hard. (He is calmer and more attuned with the therapist, but a sad grimace appears on his face briefly.)
THERAPIST: Just that flush of pain right there, you want to tell me about the worst part?

The therapist is again focusing in on the worst part to arouse the avoided activating feeling. This is a good example of the therapist utilizing the facial expression of emotion to infer an internal state.

PATIENT: You know, him, he's just seven (hesitating a bit, rubs his face, looks down, inhibition rising). He's smart.
THERAPIST: He's just a little guy.
PATIENT: Yeah, he's a little guy, he's behind in school (continues to rub his eyes). He's behind, he's behind (tears seems to be appearing) the curve, every time . . .
THERAPIST: Yeah, yeah.

The therapist is empathically supporting the patient's initial expressions of the activating feeling, encouraging him to continue experiencing the sadness.
Affect Phobia Therapy

PATIENT: I get to see him for a year, and then he is gone for a year.
THERAPIST: You didn’t get to see him for a year.

The therapist is restating the patients’ response to help him experience the significance of what he is talking about.

PATIENT: No, and ah.
THERAPIST: What must that have done to you?

The therapist is again focusing in on the patient’s emotionally felt experience of his separation from his son.

PATIENT: It was terrible, you know you think about, not every day, I don’t think about him every day, but I think about him often.
THERAPIST: And what would you be feeling in your heart?

The therapist is orienting the patient toward his affective reaction rooted in his heart, where he identified the somatic experience of his affective response.

PATIENT: Mad, sad, mad, you know.
THERAPIST: Mad, sad, and all those.
PATIENT: Sure, you know it’s rough, some days some nights I wait long.
THERAPIST: You’ll have a long painful worry, what do you worry the most about?

The therapist is restating the patient’s response to encourage sadness. Notice how the patient also brought up that he was feeling angry. While anger certainly can be an adaptive response to his experience with his ex-partner, the response is now interfering with experiencing sadness and actually has a defensive function, as we discussed earlier. Notice that the therapist did not say that the anger is maladaptive. There is a refocus of attention, and the anger might be brought back up at a later time in therapy. The therapist is therefore trying to redirect the patient to experiencing the sadness. This illustrates two important points. First, it is important for the therapist to follow his or her conceptualization of the client, based on the conflict triangle; here the therapist has conceptualized sadness/grief as the central suppressed activating affect and that anger is being used defensively. Second, such conceptualizations should, however, be considered hypotheses, and the continuing work will determine the role of anger for this patient. The therapist will want to keep in mind the uncertainty about the role of anger and to test his or her hypothesis that sadness and grief are
central, but for now, the therapist follows the working conceptualization of this client.

PATIENT: (sorrow starting to appear; he is rubbing his eyes again) That he is not getting what he needs. His mother [inaudible] she is smart, you know, but, for instance (looks sad, swallows, tears rolling down his cheeks) first time when he came to live with me for a stay . . .

THERAPIST: He lived with you for 5 months.

PATIENT: Yeah, but then his mother came and snatched him up. I didn’t see him for a year before that, and then she kind of just dropped him off—“I’m moving to Arizona”—you know, I saw him for a couple of weeks before that. And when I got him, he couldn’t wipe himself properly, he couldn’t tie his shoes . . .

THERAPIST: Let me just slow you down a little bit. One way you stay away from the feeling is talking fast. Let’s just take a deep breath and stay with it, cause that must have broken your heart.

The therapist observes that there is a mismatch between the displayed emotion and the story the patient is telling. The therapist is trying to help him experience the grief by allowing it to have space to come to the surface. Reducing the pace of his talking allows him to pay attention to bodily activations associated with his story.

THERAPIST: When you got him back he’d been gone for a year, and he couldn’t wipe himself . . .

The therapist is restarting the history from the beginning to help him experience the affect in his story.

PATIENT: Right, not properly.
THERAPIST: So he really seemed to be neglected.

The therapist is trying to redirect the patient toward the hardest parts of his story, what holds most potential for the patient to experience the avoided sadness.

PATIENT: He sat in front of the TV you know (getting more in touch with sadness). He was watching movies he shouldn’t watch.

The therapist is continuing to orient the patient toward sadness, the avoided activating affect. The excerpt of the session has showed how initially just talking about the avoided affect led the patient to defensive
laughter, but that the patient was made aware of this and the function it served. After the strong association between the activating affect (sadness) and the defenses (laughter) had been pointed out and worked with, the therapist’s effort turns to helping the patient experience the sadness that had been inhibited. A sense of pity and shame was activated when getting close to sadness, and this greatly reduced the patient’s experience of the activating affect. As shame is related to the belief of someone observing and judging the person, the therapist focused on testing out and changing the assumptions the patient had about shame. Another strong force in changing shame is the therapist’s reaction when the patient was expressing whatever affects or behavior with which the shame is associated. After working with helping the patient to experience more adaptive levels of shame and having a more realistic view of other people, the therapist oriented the patient back to experiencing the sadness connected to the separation from his son. Although this summary displays the parts as fairly separated objectives that is worked with in a chronological way, the process is often very dynamic, with the therapist switching back and forth from working on the different corners of the triangle of conflict, but with the same aim in sight: helping the patient resolve the affect phobia. The triangle of conflict for this patient had sadness or grief at the bottom corner, shame as the primary inhibitory affect, and laughter as a prominent defense. However, in the remainder of the session it became clear that another activating affect with a lesser phobia attached to it was anger. The therapist chose to work with sadness first for two reasons: the phobia seemed to be stronger for grief, and anger was aroused when the patient was getting in touch with the sadness. This could indicate that aggression served a defensive function to help the patient avoid experiencing the sadness, in addition to a healthy activating self-asserting affect connected to the ex-partner’s behavior with his son.

It is evident in the session that the patient was beginning to experience previously avoided affects, recognize and understand his maladaptive patterns in light of the triangle of the person, and reorganize his view of himself and of others in important areas. Continuation of the therapy would have proceeding along the lines of this session, with efforts made to tie this work into his current relationships with his son and his new family.

**Future Directions**

APT is at its core a transdiagnostic approach. That is not to say that every patient is treated equally, but that every patient has his or her unique formulation of the triangle of conflict and the triangle of person. The therapist must investigate and test out his or her hypothesis and develop an understanding for the patient’s affect phobias. APT is best delivered by
a skilled therapist who is not afraid of strong feelings, feelings that some might find uncomfortable to experience even in the setting of a therapeutic relationship. The therapeutic work is aimed directly at the patient and his or her affect phobias as they arise experientially in session. Because the affect phobias are often developed in close attachment situations, this raises possibilities of transporting affects from other relationships into the therapeutic relationship (i.e., transference and countertransference reactions). These reactions can be challenging for the patient, as well as for the therapist, even if one is aware of the function of the affect. With some experience and guidance the approach is manageable to most therapists, however.

Principles from APT are transferrable to other therapy orientations. In particular understanding the relationship between defenses, activating and inhibiting affects, their function and how they interfere with each other to regulate, diminish, or block each other can be central to understanding the patient’s reactions in therapy and in the patient’s life. Further, interventions from APT can be integrated with other therapy orientations to help arouse affects, regulate affects, and handle maladaptive defenses, both from the triangle of conflict directly, but also from the triangle of person indirectly.

In CBT, the focus is often on regulating emotions that are explicitly problematic by attenuating their expression. For example, the CBT therapist might work toward managing one’s anger or using relaxation and cognitive reappraisals to reduce fear. Clearly, there are instances when the CBT therapist wants to activate the patient, which would be the case for depression, but this is usually done through behavioral (e.g., behavioral activation) or cognitive strategies (e.g., Beckian cognitive therapy). APT provides a complementary strategy that focuses directly on the expression of activating affects that are being avoided. Incorporation of APT techniques provides the CBT therapist with a range of options for intervention that would include behavior, cognition, and affect.

**Further Resources**

- For a manual detailing the treatment objectives and suggestions for interventions, see McCullough et al. (2004).
- For a more in-depth description of the foundation for APT, see McCullough Vaillant (1997).
- APT has an online teaching tool for learning how to identify central objectives in the patient during therapy. See www.ATOStrainer.com, and McCullough, Bahtia, Ulvenes, Berggraf, and Osborn (2011).
- A video recording of an affect phobia therapy session has been published through the American Psychological Association (affect-focused dynamic psychotherapy; see www.apa.org/pubs/videos/4310728.aspx).
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References


way of describing psychotherapeutic processes. *Journal of Consulting and Clinical Psychology*, 64(6), 1306–1315.


