Performance anxiety is rampant in our culture and is one of the most prevalent forms of anxiety. Jerry Seinfeld once joked that at a funeral, “Most people would rather be in the casket than giving the eulogy!” In fact, there are abundant examples of anxiety disorders in popular films (e.g., Engstrom, 2004) that can illustrate how to use short-term dynamic psychotherapy (STDP).

In the British comedy Four Weddings and a Funeral, Father Gerald is a priest with performance anxiety who must present bridal vows before a large wedding party. He enters the church licking his lips and gulping for air. Possibly hoping to appear pious, Father Gerald backs against the wall of the
church, and pretends to read his Bible. In fact, he is beside himself with terror.

When he finally arrives at the altar, he forgets the bride and groom’s names. He refers to the holy ghost as the holy goat, and asks the groom to take the bride to be his awful wedded wife. He ends the ceremony reciting, “The Father, the Son, and the Holy Spigot...uh, Spirit.” Father Gerald has performance anxiety. And it’s bad!

Broadcast News is another film that vividly portrays performance anxiety. During a live broadcast, the news announcer drips with sweat, turns pale, and sniffs his lips. He asks, “Just how noticeable is this?” A colleague responds, “This is more than Nixon ever sweated!” During a commercial, the crew rushes the news set, aiming a hair dryer at his hair and pushing fresh shirts at him. In his final report he refers to the death of 22 people and—while still on camera—utters to himself, “I wish I were one of them!”

Finally, the master of anxiety, Woody Allen, gives us a classic example as an anxious suitor in Play It Again, Sam! He is besieged with anxiety before his first blind date after a divorce. As his mutual friend greets his date at the door, he tells himself to embody his idol, Humphrey Bogart: “I am an absolute master.” Not quite. He frantically struggles to put on his coat, and, in frustration, flings it across the room, with the sound of glass breaking in its path. He wrings his hands and babbles senselessly. His friend whispers protectively, “Alan is a triflfe tense.” The date replies, “Is he on something?”

Such examples of performance anxiety are common presenting problems in therapy. How could Father Gerald be helped to become poised? What would transform the news anchor into a confident announcer? What does the anxious suitor need to become calm and self-assured? How would a therapist using STDP treat this all-too-common problem? In this chapter we first describe the basic concepts of STDP, then we use the film characters presented here to illustrate how performance anxiety is treated in STDP.

SHORT-TERM DYNAMIC PSYCHOTHERAPY

The STDP therapist conducts an in-depth diagnostic and historical evaluation to determine a hypothesis for treatment and to evaluate whether STDP is appropriate for the patient with a GAF off 55 or above (Endicott, J., Spitzer, R.L., Fleiss, J.L., & Cohen, J. 1976). Questions include: Are there other existing axis I and axis II diagnoses? What is the intensity and duration of the overwhelming anxiety? What are the symptoms of physiological arousal? Is the person’s functioning sufficiently compromised for medication to be considered? How old was the patient when the first signs of performance anxiety emerged? Was there a precipitating event? And so on. In STDP, the initial evaluation is often two to three sessions in length to permit an in-depth exploration of these matters and to determine whether the patient can tolerate the rapid uncovering of feeling—the hallmark of this affect-focused treatment.

Specific to STDP is the understanding of several concepts:

- Affect phobia
- The Two Triangles
- Restructuring defenses, affects, and attachments

Affect phobia refers to what feeling is avoided. The Two Triangles describe how the avoidance of feeling happens and with whom. Restructuring refers to the exposure and response prevention mechanisms that are used to desensitize the affect-phobic individual.

AFFECT PHOBLA

Most people are familiar with external phobias—the fear and avoidance of such things as bridges, spiders, elevators, blood, open spaces, social situations, or heights. In contrast, affect phobias are less well-known internal phobias in which people are afraid of the experience of a specific feeling. Prominent examples are being ashamed to cry, afraid to stand up and be assertive, in too much pain to be close or tender with someone, or too guilty or underserving to feel adequate self-esteem.

Performance anxiety might seem like an external phobia—the fear of standing up in front of other people. But like so many external phobias, performance anxiety has a related, internal affect-based component: an inability to access the emotional experience necessary to give a performance comfortably. STDP theory posits that affects are our basic motivational system and that phobias about affects are the most basic impairment and the origin of many, if not most, behavior problems. Although maladaptive cognitions also play a fundamental role in pathology, we believe that affective impairment is even more basic.

Thus, an STDP therapist focuses on the inner emotional conflict about performance, the core conflict or affect phobia. The question becomes: What core affect or affects are conflicted and thus being avoided? The STDP therapist begins observing the avoidant or anxious behaviors and wonders what underlying phobic feeling was being warded off that the patient needed to access to be able not to be anxious about performance.

In this chapter we generate hypotheses about affect phobias and defensive patterns used by each of the film characters. But first, we describe the Two Triangle schema that puts these affect phobias in context.

TWO TRIANGLES

David Malan (1979), one of the pioneers of STDP, developed a conceptual schema (based on Freudian conflict theory) called the Two Triangles—The
Triangle of Conflict and the Triangle of Person—which organize and operationalize what happens, and with whom, when intrapsychic conflict develops and phobic affects result.

As shown in Figure 16.1, the Triangle of Conflict guides the therapist in identifying behaviors that represent defenses (D), anxieties (A), and underlying adaptive feeling (F).

The defense pole (D) represents the defenses that block or avoid the conflicted feelings. Defenses are many and varied, and can take the form of behaviors (avoiding bridges or social events), thoughts (“I’m no good”), and feelings (trembling rather than speaking).

The anxiety pole (A) represents the four main categories of inhibitory feelings: anxiety, shame/guilt, emotional pain, and contempt/disgust. These inhibitory feelings signal us to stop, slow down, or be on guard about ourselves or others. They are adaptive in moderate doses; however, too little inhibition can result in sociopathy or psychopathy. Too much inhibition can be crippling, as in the film characters such as the news announcer’s withdrawal when feeling anger and the anxious suitor’s feeling ashamed and acting foolish. It is the task of the STDP therapist to identify to the patient how and why they are using inhibitory feelings.

The feeling pole (F) represents the activating feelings that motivate adaptive behavior, such as grief, anger, closeness, sexual desire, excitement, and positive feelings toward the self. These are feelings endowed at birth to help us navigate through life. These healthy action tendencies become phobically avoided because they have become associated with something negative. The STDP therapist helps the patient understand what underlying adaptive affects are being avoided.

The Triangle of Person guides the therapist to identify the relationships in which these conflict patterns began. The past patterns can originate in past relationships (P), continue in current relationships (C), and can be played out in the relationship with the therapist (T).

Indeed, affect phobias are typically learned in early childhood from caretakers and are then practiced with others into adulthood. Children develop fears of feeling as a result of a frightening, shameful, or painful event. For example, a child may learn that sadness or anger is bad: “Big girls don’t cry! Never question what Mommy says!” When natural, healthy responses are not permitted, the child may become anxious, withdrawn, or put on a happy face instead. The STDP therapist must help the patient see the origins of these feared feelings to assist in the desensitization of the affect phobias. For example (using the Two Triangle schema):

**Therapist:** Father Gerald, can you see that your anxious behavior in church (D) as well as with me (T) is similar to how you responded last week to the bishop (C)? This pattern seems to have come from how hard you tried as a boy to please your father (P).

**Father Gerald:** It’s true. He set incredibly high standards for me, and I always was anxious about falling short of them. I can see I am still doing that.
Restructuring Defensive and Affective Patterns

STDP methods are designed to desensitize the affect phobia. These methods entail defense restructuring (decrease use of maladaptive defenses), affect restructuring (exposure to the “true” but phobic feeling), self/other restructuring (improve sense of self and relationship with others), and anxiety regulation (decrease anxiety, shame, or pain associated with that feeling). Barlow (1988, 1993) and colleagues value the use of exposure to resolve emotional and behavioral conflict. Barlow (1988) writes:

The overwhelming evidence from emotion theory is that an essential step in the modification of emotional disorders is the direct alteration of associated action tendencies...prevention of behavioral responses...associated with fear and anxiety, and the substitution of action tendencies associated with alternative emotions, may account for the effectiveness of this technique. (p. 312)

In STDP theory, we see the major change agent as the substitution of action tendencies with more adaptive forms of affective responding. Six major objectives guide treatment interventions.

The first two objectives concern two obstacles that need resolution to restructure defenses properly. The patient has to be able to recognize and understand their defensive patterns, and be motivated to give them up. It is the task of the STDP therapist to point out the defensive behaviors and educate the patient about the costs of what is being done, to encourage change.

In the film examples, Father Gerald, the news anchor, and the anxious suitor are not using traditional defenses to avoid their painful situations. Rather, each man is struggling mightily to perform, even though he is overwhelmed with anxiety, shame, and pain. In such cases, the flooding of anxiety or shame or pain blocks an effective emotional response, so the anxiety response itself serves as the defense or avoidance mechanism. The whole top of the triangle can be seen as defensive. The same question then arises: What feeling or feelings are needed that are not being accessed?

Thus, the second two objectives concern the experiencing and expression of appropriate feelings. However, before one can desensitize the affect phobia, it has to be correctly identified. Sometimes the true feeling is obvious and easy to determine, but other times, especially when it is unconscious, it can be difficult and confusing. It is helpful to remember that the choices are few. Still, many therapists become confused at this point, thinking that the “phobic feeling” that is being avoided is shame or anxiety, because, of course, no one likes these negative experiences.

The definitive question is: Does this person need more anxiety or shame to get better? Certainly not. These inhibitory feelings are causing the trouble because they are overdone. What must be identified are the activating feelings that motivate adaptive behavior but have become conflicted because of their association with anxiety, guilt, shame, or pain. Thus, the challenge for the

STDP therapist is to listen to the patient’s story and identify the natural, healthy feelings that would help the patient behave effectively and feel better.

Case Illustrations

What might we hypothesize are the true feelings that our film characters need to access to resolve their performance anxiety? What feelings would help Father Gerald overcome his performance anxiety at the wedding? What feelings does the news anchor need to stop his terror of live performance? What does the anxious suitor need to feel that would help him enjoy his date and be the confidant, warm, open man that he aspires to be?

Is there one feeling? Or several? Are all three men’s needs the same or are they different? The STDP therapist explores this by eliciting further information from the patients. Close attention is paid to the nonverbal and verbal responses toward feelings. The therapist and patient begin to link the anxieties and defenses, moving closer to uncovering the actual blocked feeling and its origins. Next we hypothesize about the film characters, but use our clinical experience with actual patients to develop their stories.

Father Gerald’s Affect Phobia

Let’s imagine that Father Gerald contacted an STDP therapist, concerned that he has done poorly in previous ceremonies and is getting increasingly anxious, which is making things worse. In addition, he is deeply disappointed in himself that he is not the inspiring priest he had hoped to be. Further discussion might uncover that he feels guilty about his hubris of wanting to be inspiring, and thus not entitled to his grief about his loss of self-image. Through a process of trial and error, the therapist makes various suggestions to be corroborated, or not, with Father Gerald.

Father Gerald: I never liked public speaking, but I used to do OK. Then one time I fumbled and was so upset over it that now I’m a nervous wreck before every service.

Therapist: So maybe you’re being too demanding on yourself and keeping those overly high standards like your father did.

It appears that Father Gerald needs to be less demanding or more compassionate about his mistakes.

The News Anchor’s Affect Phobia

The news anchor tells the therapist that he has been furious because he has been unable to negotiate a satisfactory contract with his station. He is overworked and underpaid compared with another announcer. Therefore,
he is well aware that he feels jealous, angry, and devalued, but is still unable to negotiate a better contract. The dialogue might go something like this:

News Anchor: I seem to do OK in the beginning negotiations, but I always choke up at the end and lose my initiative.

Therapist: I wonder if you're struggling with more than a block toward anger?

At this point the therapist would explore whether the news anchor feels he is not entitled to succeed, not really good enough. He might be devaluing himself as well. During the discussion the following emerges.

News Anchor: No, I've never felt adequate. I always feel like I am not good enough and am faking it and am going to be found out.

This would indicate to the therapist that the patient needs desensitization of anger/assertion, but that there is also shame or guilt about his sense of self (his entitlement to have negative feelings) that needs to be dealt with.

**ANXIOUS SUITOR'S AFFECT PHOBIA**

The STDP therapist might hypothesize that the anxious suitor lacks self-confidence or sufficient self-esteem with women. Discussion reveals several factors. He has always felt inadequate or unattractive. His family was not warm or affectionate and never praised the children. To make things worse, he had been cruelly teased by his sisters while growing up, and never wants to let himself be seen for who he is.

What emotions does he need to access to master this situation? Obviously he needs to develop a healthy self-esteem and confidence. He also may need to feel more comfortable with feelings of closeness to others because his family was cool and unexpressive. In addition, he probably would need to face his angry feelings toward his family, and grieve what he did not get as a child so that he could proceed in the future to respond differently and more adaptively.

When some hypotheses about feelings have been identified, the final question is: Why have the feelings been so avoided? What is the specific anxiety, shame, or pain that inhibits the natural, healthy response? Patients are encouraged to explore the emerging anxieties so they can develop an awareness of the fears associated with moving closer to experiencing true feelings—and learning to master them. Here are some examples from the film characters:

Therapist
[to Father Gerald]: What is the most shameful thing about not perfectly performing vows?

Therapist
[to the news anchor]: Can we look at what it is about public performance that is the most terrifying for you?

Exploiting the maladaptive cognitions and then disputing their logic is a popular and effective intervention in cognitive therapy. It is used in STDP to give the patient some perspective (developing an observing ego) to help them better cope with their fears.

Although these film characters are fictitious, their behaviors and our interpretations of their underlying problems follow typical problems in treatment that STDP conceptualizes using the Two Triangle schema. Father Gerald appears to have a mild phobia (A) about self-presentation (F). The news anchor feels shame (A) about anger or assertion (F), but also a fair amount of unworthiness (A, shame) instead of self-esteem (F), because he feels like a fake (D), and is also unentitled (A) to fight hard (F) for what he wants in his contract. He would need to build a strong self-esteem and self-image (F, positive feelings associated with the self) and become comfortable with appropriate expressions of anger/assertion (F).

The anxious suitor shows the most impairment to the self, with a great amount of shame and feelings of being unattractive, unlovable, and worthless (D, self-attack). He also mentions anxiety (A) about closeness (F) since childhood. The anxious suitor would need to become confident and positive (F) about himself, unafraid to be close (F) to others, and probably also have to feel grief (F) and anger (F) to early life figures (P) until he could feel better about himself (F) and put his family in perspective.

The STDP therapist would then encourage these patients to explore the hypotheses (interpretations) and revise them if necessary. In this collaborative process, the patient begins to understand his defensive behavior, his inhibitory anxieties, and the underlying avoided feeling.

The hypothesis about the affect phobia is always a work in progress, an educational tool constantly being reshaped and expanded throughout the treatment by both the patient and the therapist. We can never know if the hypotheses are correct or historically accurate. We can only hope the hypothesis rings true and that it is effective in guiding interventions that result in behavior change.

Despite the careful identification of the defensive patterns, awareness or insight is rarely sufficient for change to occur. Most often, the patient must be exposed to the avoided affect and learn how to experience true feeling.
without the negative intrusion of excessive inhibitory anxieties and defensive behaviors.

At this point, the STDP therapist (armed with the core conflict formulation to guide the interventions) and our film character patients (ideally with defenses sufficiently restructured to have acquired enough insight and motivation to bear the process) move to affect restructuring to desensitize their respective affect phobias.

There is abundant research that demonstrates that the most effective treatment for a phobia is exposure and response prevention. STDP treatment follows similar premises. Effective treatment involves exposure to the phobic feelings to reduce the inhibitory feeling that prevent these feelings from being properly expressed.

Similar to a behavior therapist helping a bridge-phobic patient approach a bridge, the STDP therapist must assist affect-phobic patients in approaching, bearing, and incrementally working through the bodily experience of anger, sorrow, tenderness, or pride that has become conflicted and warded off. Similar to behavior therapy, the STDP process is initially conducted in imagery to desensitize the inner experience of feeling, and then in vivo to desensitize the outer or interpersonal expression of feeling. The therapist is also vigilant for the avoidant defensive responses and helps alert the patient to prevent those responses.

There are three main components for the process of desensitization of affects. First is to prevent the defensive responses by pointing out avoidance and to refocus the patient. Second is to expose the patient to the phobic affect, guiding the patient to experience the feeling on a visceral level for behavior to change. Gestalt techniques are very useful here. And third, reduce the associated inhibitory affects (anxiety, guilt, shame, pain). Cognitive techniques work for this.

Gestalt techniques and guided imagery are excellent methods for exposing patients to the experience of a feeling that they once learned not to have. Desensitization is achieved through repeatedly exposing the patient to the feeling until whatever anxiety, guilt, shame, or pain that has become associated with it is lessened. The STDP therapist is vigilant for signs of adaptive responding and encourages the patient to make behavioral ratings of improvement every few weeks.

The STDP therapist will help Father Gerald face that he is not yet as inspiring in his performance as he would have hoped. This should elicit some sorrow on his behalf and help him bear that he will make mistakes sometimes. Father Gerald needs to see the high standards he sets for himself (defense of perfectionism), and become more accepting and compassionate (F) toward himself.

Therapist : They probably think I am a fool and incompetent to do my job.

Father Gerald : Is that what you would feel if you saw a young priest in your shoes?

Father Gerald : No. I would feel sympathetic toward him and know he was nervous.

Therapist : Well, isn’t it sad that you feel sympathetic toward this imaginary person, but not for yourself? And you worry that your congregation would think so badly of you, but when you imagine yourself in the congregation, you feel sympathetic. Don’t you think you’re being pretty hard on yourself?

Father Gerald : Yes, I can see that. And it’s just what my father did.

Therapist : I wonder if you can let yourself feel gentler toward yourself?

The subsequent exposure to self-acceptance reduces a good deal of the anxiety and shame about performance, and takes some of the burden off his performance anxiety. Father Gerald has some areas where he feels self-worth, so that he can readily accept that he does not always have to be a perfect performer. The acceptance of his imperfections as a speaker calms him, and he is now able to reassure and calm himself as he begins the services. Although this is a fictitious example, his absence of severe impairment to the self, and the rapid resolution of his anxiety, follow some well-trodden pathways of cases that are classic short-term treatments that might last five to ten sessions.

In the case of the news announcer who is blocked in standing up for himself, the therapist must desensitize the experience of feeling appropriately angry or assertive. This will enable him to set limits or ask for his needs to be met. He also needs help with restructuring his impairment to his sense of self so that he feels worthwhile and entitled to stand up for himself.

Exposure to the avoided feeling must be felt on a physiological level to be effective, and may begin with small and tolerable doses. The process starts by the patient describing a specific problematic incident in vivid detail, as if it were really happening in the moment, to help the patient to access and experience the emotions associated with the scene.

The process might involve interactions like this:

Therapist : You mentioned how difficult it is for you to negotiate for yourself. Could you imagine being back in the boss’ office when you were going over the contract? What were you feeling toward the boss at that moment?

News Anchor : Not much toward him. I was just tied in knots. I guess I was angry at him, but couldn’t say so.
Therapist: Could you go back and try to feel some of that anger now? As though you are face to face with him? Of course, we never intend to explode in anger at anyone. We are just exploring these feelings so that you can become comfortable with them.

The therapist listens and watches, asking the patient to describe bodily responses associated with the emerging feelings (e.g., tension in hands due to feelings of anger). This use of imagery creates the "exposure" to feeling.

Therapist: What would you do if you put that angry energy out on your boss? Can you let yourself feel that? (exposure #1)

News Announcer: I hate acting like a bully. I never want to do that! (shame associated with anger)

Therapist: We are not ever talking about acting like a bully. We are just trying to explore that inner energy — and if you block it as you just did, you will not have the initiative to negotiate for yourself (disputing the logic of his shame reaction). So, could we try once more to look at those anger feelings that are part of your life force? (Therapist refocuses on the phobic affect for exposure #2.)

News Announcer: Well, in truth, I wanted to punch him in the face!

Therapist: Can you let yourself feel that — just as if you were doing it? (Later) That is the energy you want to feel, but not act out. It is the energy that will help you drive a hard bargain in a negotiation (linking the inner feeling with appropriate expression).

Exposure should be done in a stepwise and supportive manner. In this case, the therapist helps the news anchor feel a little irritation before he could fully feel and appropriately control his anger.

In contrast, the anxious suitor's feelings of worthlessness and inadequacy imply much greater impairment to his sense of self that the other two characters. The major focus in his treatment would be to access the feelings of self-worth and acceptability that are blocked by shame. The physical experience of self-worth can often be accessed by an intervention called changing perspectives. If a person is not able to feel something one way, they can often access the feeling if it is once removed, as Father Gerald did earlier. The anxious suitor needs to imagine that other people in his life feel care or compassion for him before he can experience positive feeling for himself.

Therapist: Who thought you were special when you were a child? Whose eyes lit up when they saw you?

The Anxious Suitor: No one. … (pausing) … Well, I suppose my Aunt Helen.

Therapist: How did you feel when you were in her presence? (exposure to positive feeling for self)

The anxious suitor: I felt warm and happy. She just made me feel like she loved having me around. (tears beginning to flow) No one else in my family made me feel that way.

Therapist: I wonder if you could hold on to that feeling you had with Aunt Helen and carry it with you?

Traditional forms of treatment tend not to focus directly on self-esteem, or on the desensitization of blocks to it. In contrast, positive self feelings is a major focus in STDP. Exposures, such as the one with the anxious suitor, must be repeated until shame is decreased and replaced instead with healthy pride, such as, "I am worthwhile and entitled to good things."

**CLINICAL ISSUES AND SUMMARY**

The treatment of performance anxiety is actually quite straightforward once the therapist understands how to use Malan’s Two Triangles — and determine what core affect is blocked. Desensitization through exposure and response prevention helps a person to experience true feeling, and safely leave behind destructive inhibitions. The restructuring of the self enables the patient to gain strength and wholeness, leaving behind a host of negative self-statements and inadequate self-images. The sense of self often plays a pivotal role in anxieties and defenses associated with social phobia; concomitantly, positive feelings about the self often play a role in its resolution.

STDP incorporates many effective interventions from behavioral and cognitive therapies. However, STDP is primarily focused on the exploration and identification of conflicted, and thus avoided, feelings, which we consider the fundamental origin of maladaptive behavior. Nevertheless, the psychodynamic conflict is labeled in behavioral terms (affect phobia) and treated with desensitization techniques, because research-based behavioral interventions offer effective ways to resolve problems, including those arising from psychodynamic conflicts.

In summary, to understand the affect phobia imbedded in the Triangle of Conflict, the STDP therapist helps the patient develop a hypothesis concerning how the patient avoids feelings (defenses), why the patient is avoidant (anxieties), and what the patient is avoiding (the "true" or "phobic" affect). Thus the Two Triangles become operational by answering these questions that then guide the STDP interventions.

Common factors by Lambert and Bergin (1994) have been intentionally incorporated throughout the STDP process. Defense recognition was designed as a method for achieving awareness or insight. Defense relinquishing is the way
we help build motivation. Affect experiencing is the process of exposure to and desensitization of conflicted feelings, and affect expression is the process of acquiring new learning about how to manage and convey those feelings appropriately. In addition, the STDP therapist constantly offers reassurance in an empathetic and caring manner, provides ongoing teaching so that patients can learn to articulate their experience, and gives encouragement for patients to face their fears and continue to practice repeated exposure to fearful and conflicted feelings.

This model of STDP has been developed and refined from research findings during the past 25 years. In addition to research supporting the efficacy of the common factors incorporated in STDP, there have been two randomized controlled clinical trials supporting the efficacy of this model. The first clinical trial (Winston, McCullough, Trujillo, et al., 1991) and two-year follow-up (Winston, Laikim, Pollack, Samstag, McCullough, & Muran, 1994) as well as a series of process studies (e.g., Foote, 1989; Makinen, 1992 McCullough et al., 1994; Salerno, Farber, McCullough, Winston & Trujillo, 1992) were conducted at Beth Israel Medical Center in New York City. The second clinical trial and two-year follow-up was conducted at the University of Trondheim in Norway, comparing STDP with cognitive therapy (Svartberg, Stiles & Seltzer, 2004). Currently, a large-scale process study is underway at the Norwegian University of Science and Technology in Trondheim, Norway, where the videotapes from these clinical trials are being extensively analyzed for change mechanisms that promote improvement (e.g., Johansen, Valen, Revheim, McCullough, Stiles, & Svartberg, 2004; McCullough, Kuhn, Andrews, Valen, Hatch, & Osino, 2004; Valen, McCullough, Stiles, & Svartberg, 2003), and are being compared with change mechanisms in videotapes from other theoretical orientations such as DBT (Linehan, 1993). This model is also being intensively examined in a single-case experimental design format conducted at Harvard Medical School with the goal of continually improving the treatment offered to our patients.

Of course, our movies might not be as entertaining without the hilarious failures of Father Gerald, the news anchor, and the anxious suitor. However, with their performance anxiety resolved, these characters just might have a chance of leading lives that are fuller, more peaceful, and ultimately more productive.

Emily Dickinson, a woman beset with severe social phobia (she rarely left her house) and performance anxiety (she never allowed her poems to be published while alive), nevertheless knew its cure in her heart and mind. She reminds us in her poem 1176:

We never know how high we are 
Till we are asked to rise,
And then if we are true to plan
Our statues touch the skies.

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