

# Chapter 11

## Affect-Focused Short-Term Dynamic Therapy

### Empirically Supported Strategies for Resolving Affect Phobias

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#### Introduction

The field of psychotherapy research is in the process of solving a great puzzle. To date, differing therapies have often demonstrated similar effectiveness, and no factors have been identified that consistently capture a large portion of the variance in improvement [1, 2]. Therapeutic alliance accounts for about 22% of the variance in outcomes [2] and patient characteristics at admission an additional 20–25% [1], leaving more than half of the variance somewhat of a mystery.

What factors remain obscured in the complex and mysterious other half of the psychotherapy process? Are there powerful curative factors that have not yet been identified or are some interventions not yet powerful enough? Do we lack the proper methods to accurately capture the mechanisms that promote change or do change mechanisms need to be more context-specific and better tailored to the patient? Finally, are there mysterious, treatment-specific mechanisms that remain to be discovered?

Affect may be one of these mysterious variables. Although considered a contributor to change in many theoretical orientations and a common factor in some research studies, research on affect in psychotherapy has been equivocal. This chapter will describe a quest to explore the power of affect in psychotherapy, to better operationalize this complex and confusing construct, and to report on relevant research that might shed some light on aspects of affect that have not been previously examined.

#### The Focus on Affect in Short-Term Dynamic Psychotherapy

Short-term dynamic psychotherapy (STDP) theory hypothesizes that most patients' problems can be traced to conflicts or fears surrounding feelings [3–8]. The central premise is that psychodynamic conflict can be thought of as

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a fear about feeling, or “Affect Phobia,” and fears of feeling (both conscious and unconscious) underlie most, if not all problems that patients present [8]. For example, for the problem of unresolved losses, an underlying affect conflict or “phobia” might be: “If start crying, I’m afraid I’ll never stop!” For the problem of victimization or abuse, the underlying affect phobia might be: “I can’t possibly feel anger because I’d feel too guilty, afraid, or undeserving.” For the problem of isolation or loneliness, an affect phobia could be: “I closed my heart years ago, and I’ll never let myself be hurt like that again.” And for the problem of low self-esteem the affect phobia often takes the form: “I feel too ashamed to feel self compassion or self worth.”

Viewing psychodynamic conflicts as Affect Phobias allows therapists to treat the conflicted feelings described above as any standard phobia would be treated – by exposure and response prevention (e.g., [9]), to be discussed below. Patients are encouraged to gradually experience increasing levels of previously avoided affect (a process of exposure) while reducing anxiety or other inhibitory affects (such as guilt, shame, or pain) to a manageable level (thus preventing the avoidant response). The goal is to help patients face, tolerate and put into perspective the previously unbearable and warded-off affects.

## **The Historical Roots of the Concept of “Affect Phobia”**

The historical roots of “Affect Phobia” have emerged from the integration of “what works” in psychotherapy, such as gestalt therapy (for deepening the experience of feelings); cognitive therapy (CT) approaches (to restructure maladaptive cognitions), interpersonal interventions (to restructure relationships), and self-psychology (in restructuring the self-image). However, the central roots of Affect Phobia are based in psychodynamic theory, examining *defenses* that protect the self from painful affects through *anxieties* that block feeling and learning theory (for *exposure* to warded off feelings, and *response prevention* of defensive avoidance.) These latter two theoretical contributions will be focused on below.

## **Psychodynamic Roots of Affect Phobia**

Psychodynamic theory provides:

1. A description of intrapsychic components
2. The etiology of psychopathology
3. A description of how problem behavior originates from the resulting conflict

The strong focus on affect in therapy emerged from movements in the psychoanalytic community that began to emphasize more short-term, affect-focused models of treatment. Originally, Freud [10] hypothesized that neuroses were

attempts to avoid unpleasant unconscious experiences, and though not often stated explicitly, much of the “unconscious” material involved exposure to feelings contained in fantasies. Wanting to shorten the increasingly lengthy process of psychoanalysis, writers such as Ferenczi and Rank [62] shifted from therapist passivity to therapist activity, and proposed a number of strategies intended to shorten analysis. Alexander and French [11] extended a number of these short-term techniques, such as imposed time limitations, focus on the patient–therapist relationship, and an unrelenting experiencing of the *focal affective conflict*, to facilitate deeper and lasting change. Working with Michael and Enid Balint, Malan [12, 3] continued the focus on feeling. In Malan’s words “the aim of every moment in every session is to put the patient in touch with as much of his true feelings as he can bear” [3, p. 84]. Davanloo [4] was also influential and contributed methods for strong confrontation of defenses to unearth warded-off emotions. Growing research in the mother–infant laboratories has supported the focus on feelings (e.g., [13–15]) and demonstrated that infants are born with a broad repertoire of feelings (e.g., sorrow, joy, interest, fear, disgust) that need guidance, but not restriction. Tomkins’ [16, 17] theory of emotion provided the foundation for our affect theory.

Further work on Tomkins theory, as described in Ekman and Davidson [18] offered support for the categorization of feelings that are used in the Affect Phobia model: (1) activating affects such as grief, anger, fear that produce flight, joy (including joy or tenderness toward others), and excitement, and (2) inhibitory affects such as guilt, shame, emotional pain, and the “freezing” form of fear/anxiety.

As a result of these clinical and research contributions, emotions have begun to be considered theoretically central in psychodynamic theory, and no longer viewed as drive derivatives, but as primary motivational forces [19].

Thus, according to an updated version of Freudian conflict theory (initially described by Malan in 1979 and operationally defined by McCullough [6] and McCullough and colleagues [8], psychodynamic conflict results from conflicts surrounding feelings. It is, in essence, the opposing affective components of our motivational system. The *inhibitory* forces of anxiety, shame, guilt, or pain are acquired in early life as a result of subjectively experienced faulty attunement or neglectful or abusive interactions with caretakers, whether intentional or unintentional. *These inhibitory affects* then thwart the use of natural, healthy *activating* feeling responses such as grief, assertion, closeness, or self-esteem. Common examples of these “Affect Phobias” are guilt over anger, embarrassment about crying, pain over closeness, or shame about oneself. When adaptive activating emotional responses are blocked by inhibition, less adaptive and defensive responding will take their place. Thus, when there is guilt over anger, blocking healthy limiting setting, passivity, depression, or anxiety might result. When there is shame over crying, blocking healthy grief, overeating, pathological mourning, irritation, or again, depression can occur. These maladaptive symptoms, though unpleasant are just a few of the myriad and multiply determined ways we avoid the even more unpleasant conflicts about emotions.

## Learning Theory Roots of Affect Phobia

Learning theory provides:

1. Redefinition of “unconscious conflicted feelings” as “phobic stimuli.”
2. Mechanism of change – desensitization of the phobic stimuli by exposure and response prevention.

Several integrative theorists have proposed ways that psychodynamic and learning principles can work together. Cautela’s [20] theory of covert conditioning was the initial impetus in the development of the Affect Phobia concept [21]. Cautela taught that the principles of reinforcement and extinction could impact on internal or covert behaviors such as thoughts or feelings, just as they do on overt behaviors.

Theorists such as Dollard and Miller [22], Stampfl and Levis [23], and Feather and Rhoads [24] believed that anxiety is aroused by the experience of a specific drive or impulse, and the behavioral technology of desensitization through exposure and prevention of avoidance can be applied to drive-related imagery underlying the avoidance behavior. Dollard and Miller pointed out that Freud [25] had observed that anxiety can be steadily weakened by extinction (p. 241). In 1977, Paul Wachtel published *Psychoanalysis and Behavior Therapy*, in which he began an integration of psychodynamic and learning theories and explored fears of feelings as a form of phobia. Far before research data supported the idea, Wachtel wrote that intellectual insight in the absence of emotional arousal was inevitably “therapeutically fruitless” [26].

All of these theorists agreed that feelings, or the “efforts to gratify wants and needs,” could become repressed by anxieties. Each believed that reduction of inappropriate anxiety is central to bringing therapeutic change in problems, and that reduction could be achieved by exposure and response prevention. Each believed that neurotic problems developed from fear learned in childhood, causing problems in later life. The Affect Phobia model thus emerged from two main sources: (1) the intensive affect-focused short-term psychodynamic psychotherapy that sought active interventions to accelerate patient change and (2) the integrative theorists seeking commonalities between psychodynamics and behavior therapy. All of these approaches share a primary change agent: expose and desensitize patients to frightening feelings or “Affect Phobias.”

## Research on Affect in Psychotherapy

During the last decade, affective responding in therapy has received mixed reviews from research on its efficacy. Studies on affect can be divided into those focusing on total affective arousal, positive affect, and negative affect. According to Orlinsky et al. [27], studies of total affective arousal in response to therapist

interventions showed an association to improvement for half of studies reviewed while half showed no association to outcome, and none showed a relationship to negative outcome. Further, four studies showed a relationship to outcome for patients' experience of positive feelings and 20 of 50 studies of negative affect demonstrated significant findings with either positive or negative associations to outcome. Orlinsky concluded that "experiencing distressing and negative emotions during sessions has strong effects that can be for good or ill depending on how effectively therapists deal with them" [27, p. 345].

A recent meta-analysis paints a somewhat clearer picture with respect to the benefit of eliciting affect in psychotherapy. To overcome some of the ambiguity in previous affect studies, Diener, Hilsenroth and Weinberger [61] selected the most methodologically sound research, and only 10 out of more than 700 studies met criteria for inclusion. Therapist facilitation of affect was significantly associated with outcome, but the effect size was small ( $r = 0.30$ ). As findings suggest, and this chapter will discuss, much of the ambiguity with affect research, may not be due only to methodological issues, but also due to confounds in affect constructs.

As Orlinsky et al.'s [28, 27] review noted, the study of affect has focused on positive and negative modes. Unfortunately, this categorization does not take into consideration the many different functions affect can serve. All affects can function in a positive, relieving, constructive manner, and all affects can be used in a negative and destructive way. The resulting complexity and overlap in functioning maybe be one of the largest factors leading to confounds in research results.

## Activating and Inhibitory Affects

A categorization that offers greater potential for identifying change operations in psychotherapy is the distinction between activating affects and inhibitory affects. Affects may function to *motivate action* (assertion, grief, closeness, confidence) or to *motivate inhibition of action* (shame, anxiety). In addition, affects can be used maladaptively to motivate defensive avoidance (weepiness that is depressive rather than resolving or anger that is aggressive rather than assertive). The depressive or aggressive forms of these feelings are unlikely to correlate with improvement while their adaptive counterparts (grief, assertion) should lead to problem resolution.

The activating and inhibitory categories are supported by a number of researchers and theorists. Gray [29] proposed a theory of two motivational systems, which he called the Behavioral Activation System (BAS) and the Behavioral Inhibition System (BIS). Fowles [30, 31] demonstrated that heart rate reflects activity of the BAS, and electrodermal responses reflect activity of the BIS. Wilhelm and Roth [32] demonstrated that both the BAS and BIS are activated during in vivo exposure to fearful events.

Konorski [33] and Dickinson and Dearing [34], also proposed a bimodal categorization of “aversion and attraction.” Lang and his colleagues [35] continued this work by identifying two basic motivational systems that they labeled *appetitive* and *defensive*. These systems were further linked to specific brain regions that support activation and inhibition.

In recent years, there has been a growing literature on the behavioral activation and inhibition systems. Carver and White [63] have developed scales to test these constructs that are well validated. Sutton and Davidson [36] showed that right versus left prefrontal brain activity correlated with the BIS and BAS, respectively. They also demonstrated that prefrontal EEG activity was not significantly correlated with positive affect or negative affect scales. Such research supports the validity of this bimodal motivational system of activation and inhibition.

The Affect Phobia model is based on the premise that psychodynamic conflict results from opposition between *activating and inhibitory affects* that underlie behavioral activation and inhibition. The universal principle of psychodynamic therapy [3] is stated as “defenses and anxieties block the expression of true feeling.” In other words, phobias can occur in response to external stimuli, or to internal or interoceptive cues such as affects. Thus, in an affect phobia, anxieties are the *inhibitory feelings* that block the expression of true or *activating feelings*. When these two systems are in conflict, defenses emerge as a “compromise response” (in psychodynamic language) or as a “phobic avoidance response” (in learning theory terms).

The benefit of translating dynamic principles into learning theory principles is that one may draw on abundant behavioral research on behavior change. Principles of exposure and response prevention may be explicitly utilized to resolve these conflicts between activating and inhibitory feelings similar to the processes described in Foa and McNally [37] or Barlow [38]. The fundamental change agents involve (1) exposure to and transforming of the activating affective experience (the bodily experience of anger, grief, compassion, and so on) and (2) response prevention by reducing the amount of associated anxiety, guilt, shame or pain, and related avoidant defenses. Moreover, direct exposure is to the *physiological arousal of an adaptive form of the affect*. Desensitization does not occur in response to exposure to thoughts about feelings, words about feelings, or general fantasies or images about feelings. It is essential that the affect be experienced in the body for desensitization to occur.

## Main Treatment Objectives in the Treatment of Affect Phobias

This affect-focused form of STDP emphasizes four main areas of intervention (see [8] for a more thorough discussion):

- *Gaining Insight* – Restructuring of defenses by identifying patterns of avoidance of unconscious conflicted feelings, how they started in early life, and their present day costs and benefits.

- *Exposure to and Expression of Feeling* – Restructuring activating affects by exposure until inhibition is reduced and affects can be tolerated and expressed to others in a well-modulated and adaptive manner.
- *Regulation of Inhibitory Affects* – Anxiety, guilt, shame, and emotional pain are brought within normal limits to allow more flexible experience and expression of activating feelings.
- *Restructuring the sense of self and others* – Maladaptive inner images of self and others are altered by reduction of shame attached to self-image and exposure to positive self-feelings, as well as appropriate feelings toward others.

## Methods and Procedures used to Study Affect Phobias

This specific model of therapy has been submitted to two randomized controlled clinical trials (RCTs). The first RCT was conducted at Beth Israel Medical Center in New York City [39, 40]. Sixty-four patients were randomly assigned to two forms of short-term psychotherapy (STOP: Short Term Dynamic Psychotherapy; high confrontation vs. BAP: Brief Adaptive Psychotherapy; moderate confrontation of defenses) and a waiting list control group ( $N = 17$ ). The second RCT was conducted at the Norwegian University of Science and Technology in Trondheim, Norway. Here, 50 subjects were randomly assigned to this STDP model or to CT (Cognitive Therapy) [41].

In both studies, patients who met criteria for one or more Cluster C personality disorders and Axis I disorders of depression or anxiety were randomized to 40 sessions of therapy. Therapists were experienced, full-time clinicians and supervised by experts in the therapy modality. Outcomes were assessed in terms of symptom distress (SCL-90 [42]), interpersonal problems [43], and, in the Svartbert et al. study, core personality dysfunction (MCMI [44]) administered at admission, midphase, at termination and 1.5- to 2-year follow-up. Both of these clinical trials generated videotapes of therapy sessions that could be studied to identify change processes and two intensive programs of process research followed. Several instruments were developed and psychometrically validated in an attempt to discover the treatment mechanisms that led to improvement.

### *The Psychotherapy Interaction Coding System*

The Psychotherapy Interaction Coding (PIC) System (McCullough, L., 1987, The Psychotherapy Intervention Codes (PIC). Unpublished manuscript available at [www.affectphobia.com](http://www.affectphobia.com).) was designed to capture the minute-by-minute interaction of therapist interventions and client responses in psychotherapy sessions. Therapist interventions included questions, information, self-disclosure, clarification, confrontation, directives/advice, support, and interpretation. Patient response modes included defensive, affective, and cognitive responding. The

PIC System was a beginning attempt to assess not only therapist interventions but the impact of therapy on the patient in terms of patient response to specific interventions. Thus the PIC System can be used as both a process and a “micro-outcome measure.” The interventions are operationally defined in terms of discrete behaviors to permit comparisons across different forms of therapy.

### ***The Achievement of Therapeutic Objectives Scale***

The ATOS Scale furthered the methodology for assessing the impact of therapy on patients, by rating from 0 to 100 the amount of therapy that the patient is “absorbing.” In other words, the ATOS scale rates the degree to which the patient has “taken-in” the specific objectives of psychotherapy. For example, how much does a patient (1) gain insight by recognizing maladaptive defensive behaviors; (2) show motivation for change by giving up maladaptive behavior, (3) experience activating and inhibitory affects in the session; and (4) express the feeling in relationships outside of therapy. Thus, the ATOS scale measures the degree of impact of therapy on the patient (ATOS; [8]).<sup>1</sup> ATOS scale ratings are made for each 10-min segment of each session and are correlated with various residual measures of pre–post change at termination and follow-up of treatment. The ATOS scale is psychometrically strong, with five reliability studies [45], and one validity study [46].

### **Outcome Research on STDP**

Both clinical trials have shown that STDP is an effective treatment for Axis II, Cluster C personality disorders, and according to guidelines suggested by Cohen [47], the effect sizes are strong.

### ***Results of the BIMC RCT***

The results of the Beth Israel Medical Center (BIMC) Study (Table 11.1) demonstrated strong improvement at termination in symptoms and interpersonal functioning for both groups. The effect size on the SCL-90 for the high-confrontation group was 0.96 and the low-confrontation group was 1.11. For

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<sup>1</sup> A website for more information on the Affect Phobia treatment model can be accessed at [www.affectphobia.com](http://www.affectphobia.com). This web-site also includes (1) information about videotaping of psychotherapy, (2) the manual for the ATOS for assessment of psychotherapy process on videotape or transcripts, and 3) Psychotherapy Assessment Checklist (PAC Forms – a patient self-report form) to help determine *Diagnostic and Statistical Manual* (DSM) diagnoses and assess patient pretreatment characteristics as well as therapy outcome.

**Table 11.1** Comparison of effect sizes of change in two clinical trials of affect-focused short-term psychotherapy and a meta-analysis of short-term dynamic therapy (STDP)

Study type No. of subjects/ $R \times$ length Assessment Periods	Symptoms (SCL-90)			Social adjustment (IIP/SAS-R)		
	STDP High confrontation	BAP Low confrontation	Control Waiting list control	STDP High confrontation	BAP Low confrontation	Control Waiting list control
<b>BIMC Study</b>						
Winston et al. [68, 69] RCT: $N = 32 + 32/40$ sessions	0.96	1.11	0.46	0.80	0.70	-0.07
Controls = 17 Pre- to posttreatment Pretreatment to follow-up	0.65	0.63	0.25	0.97	0.97	0.36
<b>Trondheim Study</b>						
Svartberg et al. [41] RCT: $N = 25 + 25/40$ sessions	STDP	CT	Control	STDP	CT	Control
Pre- to posttreatment	0.65	0.73	-	0.58	0.74	-
Pretreatment to follow-up	0.87	0.95	-	1.00	1.09	-
<b>STDP Meta-Analysis</b>						
Leichsenring, et al. [48] Meta-analysis, 17 studies	STDP	CT	Control	STDP	CT	Control
Pre- to posttreatment	0.90	1.04	0.12	0.80	0.92	0.21
Pretreatment to follow-up	0.95	0.97	-	1.19	1.05	-

interpersonal functioning, effect size change on the Inventory of Interpersonal Problems (IIP) was 0.80 for the high-confrontation group and 0.70 for the low-confrontation group. At 1.5-year follow-up, the effect size of symptom gains were maintained (due to the large variance in scores the drop to 0.65 and 0.63, respectively, was not significant and interpersonal functioning was improved [ES (effect size) = 0.97, both groups]. Overall, there were no significant differences in the high- versus low-confrontation group due to large variance in scores. The waiting list control group results were not significantly associated with improvement in outcome.

### ***Results of the Trondheim RCT***

As shown in Table 11.1, both CT and STDP demonstrated strong improvement at termination in symptoms on the SCL-90 (STDP: ES = 0.65; CT: ES = 0.73) and interpersonal functioning on the IIP (STDP: ES = 0.58; CT: ES = 0.74). At 2-year follow-up, these gains were not only maintained, but also slightly improved for symptom change on the SCL-90 (STDP: ES = 0.87; CT: ES = 0.95) as well as for interpersonal functioning (STDP: ES = 1.00; CT: ES = 1.09). Overall, there were no statistically significant differences between STDP and CT on any measure across follow-up.

Based on the results of both studies, STDP has been shown to be an effective treatment for patients with Cluster C personality disorders. The effect sizes in both these clinical trials are strong, but not quite as strong as a meta-analysis of short-term psychotherapy (see Table 11.1) conducted by Leichsenring and others [48]. This may be due to the more the difficult to treat Axis II, Cluster C disorder population included in these two RCTs.

## **Process Research on STDP**

### ***BIMC Process Research Results: Confrontation of Defenses***

The initial process studies in the 1980s focused on the efficacy of the “anxiety-provoking” model of STDP. Strong confrontation of defenses was hypothesized to lead to increased affective responding and better outcomes. However, using the PIC System, a series of studies from the BIMC lab demonstrated that *supportive, empathic, and clarifying* methods generated more affect than did *confrontive* interventions. Salerno and colleagues [49] demonstrated that the higher total frequencies of therapist confrontation of defenses in the patient–therapist relationship did not predict improvement at outcome. A subsequent study [50] examined confrontations sustained over 1–9 minutes, hypothesizing that it was the *continued confrontation* that would “break through” the defenses to underlying feeling. Again, and counter to expectations, continued

confrontation did *not* predict improvement, thus adding to the growing awareness of the need for a graded and empathic procedure for identifying and giving up maladaptive forms of defenses, as well as becoming more flexible and mature in using our defenses to guide underlying affects.

In exploratory analyses of the coding data, it was noted that confrontations given along with a supportive or empathic statement by the therapist [51] resulted in a greater likelihood of expression of affect. A higher rating of therapist alliance, especially in lower functioning or more resistant patients, resulted in a better probability of improvement at outcome [51]. Patients seemed to be much more able to take in the painful information contained in a therapist's confrontation or interpretation when it was paired with a statement, which reflected understanding or care. In hindsight it may seem obvious, but the "conventional wisdom" of short-term psychotherapy at that time strongly encouraged provoking anxiety to achieve a "breakthrough" to feeling (e.g., Davanloo's, *anxiety-provoking* methods).

Next, Joseph [52] compared all therapist interventions (e.g., questions, clarifications, confrontations, interpretations, self-disclosure, support) in their relative capacity to elicit defensive versus affective responding. Like Makynen [50] and Salerno and associates [49], Joseph demonstrated that confrontation elicited more defensive behavior than any of the other eight interventions. Furthermore, clarification was the only intervention that significantly elicited affect. Apparently, the therapist listening carefully and reflecting back what the patient said prepared the patient to respond in a less defensive and more open and affective manner. Studies such as these, supporting empathy and clarification over confrontation thus called into question the techniques of early forms of STDP for altering defenses, which often involved a heavy barrage of confrontation. However, the therapist stance remained active, focused, and involved, and thus continued to differ markedly from the more classical psychoanalytic approach.

In the years that followed this research, we learned to use confrontation with a gentler touch. We now think that it was not confrontation per se that was the problem in eliciting affect, but that confrontations in the anxiety-provoking forms of STDP were used too strongly, too often, and too soon. With lower functioning patients, we now precede the confrontation of defenses with building of the self-structure and increasing self-compassion, so that when confrontations are given, they are not experienced as attacking. Sometimes, we blend confrontations with supportive statements (e.g., "This may have been the best you knew to do at the time [*support*], but do you see how you are always avoiding conflict now? [*conf*]"). Or, in other cases, we might include a recognition of the patients' strengths with the confrontation, to help it be better received (e.g., "On one hand you have achieved a great deal in the professional world [*strength*], but the stories you tell of your personal life suggest that you might be sabotaging opportunities for closeness by demanding perfection from others [*conf*] What do you think?"). Such statements allow us to move as rapidly as possible with the uncovering process, but the supportive components help to protect as well as strengthen the patients' vulnerabilities around their

sense of self. Patients often exclaim, “I am so relieved that you help me remember my strong points, when I am having to look at all these stupid things that I have been doing!” At which point the therapist might respond by saying, “Why call it stupid?” “Wasn’t it the best you knew to do at the time?”

Thus, we have learned that a “spoonful of sugar” helps the confrontive medicine go down. Our clinical experience has taught us that the uncovering process is not only *not* lengthened in this process, but therapy moves much more smoothly, and gentler confrontations avoid therapy ruptures. Consequently, there is a need for a new thrust of research on these more evolved forms of confrontations. We suspect that the outcome, in eliciting affect, might be improved.

### ***BIMC Process Research Results: Affect Experiencing***

Three studies at BIMC supported the need for sustained experiencing of feeling, while one study did not. Porter [53] demonstrated that the overall frequency of patient feeling did *not* correlate with improvement and the overall frequency of defenses did not predict poorer outcomes. These findings ran counter to theory, intuition, and clinical experience. However, a later study demonstrated that patient affect and defense are only predictive of outcome *when in response to therapist intervention* [54]. This study emphasized the importance of understanding context in relation to patient response. Taurke and colleagues [55] demonstrated that the greater the ratio of overall expressed affect to defense, not only in response to therapist intervention, the greater the improvement at outcome. Patients who improved the most changed from experiencing one episode of expressed affect per every five defensive responses at admission, to one affective response for every two defensive responses at termination. Moreover, the five least improved patients showed no change in the 1/5 affect/defense ratio shown at admission. These studies provided pivotal support for Malan’s [3] assertion that lowering defensiveness in relation to affective expression will contribute to improvement in outcome.

Viewed as a whole, the BIMC process studies underscored the need for techniques to elicit affective expression and for overcoming the defensive obstacles to affective expression, but with gentler methods than initially thought. The objectives in the short-term Anxiety-Regulating Treatment of Affect Phobias described in this chapter have thus evolved from empirical evidence.

### ***The Intensive Process Analysis of the Trondheim Psychotherapy Research Program***

Since 2001, the TPRP has been involved in the intensive process analyses of ATOS-coded videotapes from the Svartberg and Stiles RCT. These studies provide the opportunity to evaluate the change processes in STDP, and carry further the research begun at BIMC. Many areas of research are underway that

include (1) ATOS variables in relation to outcome, (2) defense mechanisms and outcome, (3) differential responding across diagnostic categories, and (4) the relationship of specific affects to outcome. Process research is labor intensive so it will be many years to collect the necessary data. This chapter reports the preliminary results on three ATOS variables in relation to patient outcome.

The Trondheim program focuses on later sessions to identify factors that occur as a result of a growth process during treatment. Thus, sessions 6 and 36 of a 40-session treatment were rated. ATOS variables were levels of inhibitory feelings, activating feelings, and adaptive sense of self. Data were available from videotapes for 23 of 25 subjects in both CT and STDP. Missing data was due to corrupted videotapes or unrecorded sessions. We hypothesized that activating affect and sense of self would increase over time, while inhibitory affect would decrease over time, and that the mean levels of these variables late in therapy (e.g., at session 36) would be predictive of improvement. An averaged standardized composite outcome score was created and ranked patients according to those who were most to least improved on (1) combination of symptoms, (2) interpersonal relationships, and (3) character pathology (SCL-90 + IIP + MCMI-C/3). A standardized composite admission score was computed in the same manner and used as a covariate. Each ATOS variable was entered into a hierarchical regression with two covariates; a composite outcome premeasure and alliance ratings by the patient at session 4 (Working Alliance Inventory; Horvath and Greenberg [64]).

### *Trondheim Process Research Results: Activating Affect*

As Table 11.2 shows, the average level of activating affect in the STDP group at session 6 was 29.4 (SD = 12.7; range = 8–52). By session 36 the average level of activating affect increased 9.2 points to 38.6 (SD = 16.0; range = 10–70). The cognitive group was quite similar to the STDP group at session six with an average level of activation of feeling at 30.4 (SD = 10.5; range = 15–52). By

**Table 11.2** Mean ATOS levels of activating and inhibitory affect and sense of self at sessions 6 and 36: and relationship to composite outcome score at termination in short-term dynamic therapy (STDP) and cognitive therapy (CT)

ATOS variables and session number	ATOS levels in STDP	ATOS levels in CT
Activating affect: session 6	29.4 (SD = 12.7)	30.4 (SD = 10.5)
Activating affect: session 36	38.6 (SD = 16.0)*	32.5 (SD = 17.1)
Inhibitory affect: session 6	57.8 (SD = 16.7)	56.2 (SD = 15.2)**
Inhibitory affect: session 36	46.9 (SD = 17.9)	44.37 (SD = 15.1)**
Sense of self: session 6	34.7 (SD = 12.9)	36.4 (SD = 13.3)
Sense of self: session 36	48.0 (SD = 21.4) <sup>§</sup>	48.5 (SD = 16.7) <sup>§</sup>

Relationship to composite outcome score:

\*  $p = 0.03$ ; \*\*  $p = 0.000$ .

<sup>§</sup>  $p = >0.01$ , only when both CT and STDP groups were combined. Association with outcome was not significant for each group separately.

session 36, activating affect in the CT group had increased on average only 2.5 points to 32.5 (SD = 17; range = 5–64). In addition, Table 11.2 indicates that level of inhibitory affect at session 6 was significantly associated with outcome in the cognitive group, but not in the STDP group. This finding is in line with other research that shows that CT achieves symptom change quickly because it focuses on symptoms early in treatment. Interpersonal and dynamic models show similar change, but achieve that change later in treatment (e.g., [56]).

Figure 11.1 shows an excerpt of the activating affect scale thus placing these ratings in clinical terms. Both groups at session 6 were at the top edge of the *slight affective arousal* level (i.e., minimal or barely visible signs of feelings). By session 36, the STDP patients averaged an increase to the top of the *low affective arousal* level and nearly to the 41–50 *low-moderate arousal* level. The cognitive group increased only 2.5 points in 30 sessions (indeed their focus was not on this form of feelings) and activating affect in CT no longer was significantly associated to outcome at session 36. The low-moderate level refers to “mild feelings with much holding back.” Surprisingly, this relatively low level of activating affect was significantly associated with outcome in the STDP group and captured 8% of the variance in outcome. In this regression, alliance remained the stronger factor with the expected 22% of the variance, and the pretreatment composite received 17%.

### *Trondheim Process Research Results: Inhibitory Affects*

The average level of inhibitory affect in the STDP group at session 6 was 57.8 (SD = 16.7; range = 28–91) and by session 36 this level had dropped 10.9 points

51–60	<b>Moderate affective arousal.</b> Moderate feeling; moderate duration/moderate holding back, e.g. tearing up, moderate anger, some tender feelings as shown in face/vocal tone/body. Imagery or memories with moderate emotional content. Some relief.
41–50	<b>Low-moderate affective arousal.</b> Mild feeling with much holding back shown in face, vocal tone or body, e.g. briefly tears up, raises voice a little in anger, or says a few tender words for short duration, speaks openly. Imagery or memories with some emotional content. Mild relief.
31–40	<b>Low affective arousal.</b> Low, quickly passing experience of feeling shown in face, vocal tone or body; e.g. clenching fist, sighs, grimaces, choking up, slight sadness/anger/care for self but quickly stopped. Imagery or memories with low emotional content but appears very restrained/held back/constricted. A little relief.
21–30	<b>Slight affective arousal.</b> Minimal or barely visible/audible signs of feeling of short duration shown in face, vocal tone or body. May report slight change in internal bodily state. Imagery/memories have only slightest expression of feeling. Almost no relief.
11–20	<b>No affective arousal, BUT bland verbal report of feeling.</b> Almost no expression on face. Flat/dull/bland tone of voice, stiff or barely moving body. Patient may sense a change in internal bodily state, but is unsure whether it is a feeling or not. Only bland, unfeeling report of images or memories with emotional content. No relief.

Fig. 11.1 Excerpts of levels of activating affect on ATOS

to 46.9 (SD = 17.9; range = 20–89). Again the cognitive group was quite similar to the STDP group at session 6 with an average level of inhibitory affect of 56.2 (SD = 15.2; range 17–84) and by session 36, inhibitory affect had decreased on average 11.9 points to 44.37 (SD = 15; range = 12–68).

The inhibitory affect ratings on the ATOS (Fig. 11.2) show that both CT and STDP patients demonstrated a *moderate* level of inhibitory feelings (i.e., “anxiety, guilt, shame or pain was visibly evident in body language, vocal tone, or verbal report”). Both groups dropped between 11 and 12 points to a *low-moderate* level of inhibition (41–50). However, decrease in inhibitory affect was significantly associated with improvement only in the cognitive group ( $p = 0.001$ ) and not in the STDP group. In CT, inhibitory affect captured 22% of the variance in outcome, and exceeded that of the alliance (17%).

It was unclear why decrease in inhibition was not related to outcome in the STDP group, until we rated a few tapes at session 16 and 26. In the CT group, inhibition appears to drop steadily throughout treatment, but in the STDP group, anxiety rose to high levels in session 16 tapes, in response to confrontation of defenses, and then dropped to and remained at low levels as activating affect emerged. This rise, then fall, in the inhibitory affects may be the reason that inhibitory feeling in STDP did not directly correlate with outcome, but we must await further data collection to confirm preliminary findings.

Nevertheless, the very positive results of the CT reduction in anxiety call into question, once again, the value of the STDP’s use of confrontation to provoke anxiety. Further research is needed to see if a similar rapid reduction in anxiety would improve outcomes in STDP. It is interesting to imagine what the effects on outcome would be in *both groups* if levels of anxiety or shame could be reduced to levels even lower than we see in this study. The association with

71–80	<b>Strong Inhibition.</b> Strong inhibitory affects. Much shakiness, hesitation, sighing or guardedness in tone of voice or non-verbal behavior. Restrained, withdrawn non-verbal behavior. Very much discomfort.
61–70	<b>Much Inhibition.</b> Much inhibitory affect. Much shakiness, hesitation, sighing or guardedness in tone of voice. Some restraint or withdrawal in non-verbal behavior. Much discomfort.
51–60	<b>Moderate Inhibition.</b> Moderate inhibitory affects with moderate weakness in vocal tone; bodily movement vs restraint (moderate shakiness/hesitation/sighing, guardedness, slowness). Moderate discomfort.
41–50	<b>Low-moderate inhibition.</b> Some inhibitory thoughts or feelings. More fullness than shakiness/hesitation/sighing or guardedness in vocal tone or behavior. Less than moderate discomfort.
31–40	<b>Low inhibition.</b> Low inhibition. Only slight shakiness/hesitation/sighing/guardedness in voice or restraint in bodily movement. Low discomfort.
21–30	<b>Little inhibition.</b> Minimal or fleeting inhibition. Tone of voice or non-verbal behavior suggests a little discomfort.

Fig. 11.2 Excerpts s of levels of inhibitory affect on the ATOS

outcome in the cognitive group is already very strong. How much of the variance in outcome would be demonstrated if inhibition could be reduced to the low (31–40) or minimal (21–30) level in both groups?

### ***Trondheim Process Research Results: Sense of Self***

The average level of positive sense of self at session 6 in the STDP group was *low-moderate* or 34.7 (SD = 12.9; range = 29–40). By session 36 the average level of sense of self had increased 13.2 points to 48.0 (SD = 21.4; range = 38–58). The CT group at session 6 had a *low-moderate* level of sense of self of 36.4 (SD = 13.3; range = 30–42). By session 36, sense of self had increased 12.1 points to 48.5 (SD = 16.7; range = 42–55).

Patients in both groups were rated on the ATOS (Fig. 11.3) as having a “somewhat maladaptive sense of self.” Thirty sessions later, both groups had improved to a level of “mixed maladaptive and adaptive view of self.” By the end of treatment, patients, on average, were approaching the next level indicating a “slightly more adaptive than maladaptive sense of self.” This is an important accomplishment in a relatively short time. Some of the most exciting work in brief therapy is the active, focused work directly on feelings about the self. At session 6, the level of sense of self was not related to outcome. By session 36, the level of sense of self in both CT and STDP approached significance in relationship to outcome (STDP,  $p=0.065$ , CT,  $p=0.085$ ). When the two

61–70	<b><u>Somewhat adaptive sense of self:</u></b> Some pride in own strengths, and some affirming of own wants and needs. Some ability to acknowledge and accept limitations. Some compassion and self acceptance, but moderate self-blame or shame present.
51–60	<b><u>Mixed adaptive/maladaptive view of self:</u></b> Slightly more adaptive than maladaptive view of self. Slightly more pride than shame in self. Compassion & self-acceptance slightly greater than devaluation or grandiosity. Only moderately affirming of own wants and needs. Only a little more compassion and self-acceptance than self-blame or shame.
41–50	<b><u>Mixed maladaptive/adaptive view of self:</u></b> Slightly more maladaptive than adaptive view of self. Slightly more shame than pride in self. Devaluation or grandiosity is slightly stronger than self-compassion or acceptance of limitations. Only moderately affirming of own wants and needs. Slightly more self-blame and shame than compassion for self.
31–40	<b><u>Somewhat maladaptive sense of self:</u></b> Some shame in self. Minimal pride in own strengths. Somewhat affirming of own wants and needs in relation to others. Somewhat able to acknowledge and accept limitations. Some compassion and self-acceptance of self regarding limitations, but more self-blame or shame.
21–30	<b><u>Very maladaptive sense of self:</u></b> Much shame in self. Little pride/some grandiosity. Almost no affirming of wants and needs. Minimal ability to acknowledge and accept limitations and minimal ability to control impulses. Minimal compassion and self acceptance of self regarding limitations. Much self-blame or shame.

Fig. 11.3 Excerpts of levels of image of the self on ATOS

groups were combined, the level of sense of self was associated with the composite outcome ( $p = 0.009$ ) and captured 8% of the variance. In this regression analysis, alliance accounted for 16% and the pretreatment composite outcome measure (explained on p. 261) accounted for 29.5% of the variance in outcome. Although it is commonly believed that the self-image does not change quickly, this data shows that within 30 sessions the sense of self improved on average, from being more maladaptive to close to being more adaptive, and that it significantly contributed to outcome.

As with the two affect variables, it is interesting to speculate what percent of the variance would be captured by change in sense of self if the average level of patients' self-image could be brought up just one level on the ATOS (61–70) "somewhat adaptive sense of self," that includes "some pride in oneself, some affirming of one's needs, some compassion or self-acceptance").

In summary, the preliminary ATOS data tell us that, first, a low-moderate ATOS level of activating feelings is associated with improvement in the STDP group. This finding is in line with STDP theory – exposure to feeling leads to resolution of the conflicted affect. Second, a low-moderate level of inhibitory feelings (e.g., anxiety, guilt, shame, pain) is very strongly associated with improvement at outcome in the CT group. Again, these results are in line with what is observed clinically as CT focuses more on reduction of anxiety or shame. Also, a lowered ATOS level of inhibitory feeling in session 36 captured more of the variance (27%) than alliance (17%). Finally, a near to moderate ATOS level on sense of self in both groups combined is significantly associated with improvement. It is well known that therapies of different names may rely on the same underlying mechanisms of change [35, 57–60]. Yet, the effects of activating and inhibiting affects show quite different and theoretically consistent pathways that ultimately arrived at the same level of outcome in CT and STDP groups.

It is important to remember that this data is based on two sessions out of a total of 40 and that these are preliminary analyses on specific treatment groups. We do not yet know if one session is representative of the beginning or end of treatment, or if a larger percentage of sessions are required to accurately capture what is taking place. In the coming years we will continue rating several thousand sessions on a number of different instruments with the objective of more clearly identifying the main ingredients of psychotherapy. However, these findings are consistent with STDP theory and lend support that we are moving in the right direction.

## **Future Directions for Practice and Research**

These preliminary process findings may offer guidance for training of therapists. In the 31–40 range of low-moderate affective responding, there remains much unprocessed grief, and much untapped anger or compassion for self. What if patients could be exposed to slightly higher levels of feeling? What if therapist skill could improve so that their capacity to elicit patients' conflicted

feelings increases? These are the challenges we face as psychotherapists. Instruments such as the ATOS give feedback on patient growth and change, and may thus be of help in developing greater mastery of therapeutic skills.

Future research will explore what levels of affect experiencing and self-restructuring are optimal for change. At this point, we hypothesize that a high moderate level (ATOS rating of 61–70) would be optimal exposure (full feeling but not so high to be disorienting or overwhelming) and if attained, might capture a large and significant proportion of the variance in outcome. Additional work is underway to rate the initial evaluation session as well as sessions 16 and 26 so that we will be able to analyze changes across time. Many other process studies are planned and others are underway in the Trondheim program as well.

## **Case Illustration of Objectives and Intervention in Resolving Affect Phobias**

### *The Melancholic Grandmother*

The following is an illustration of how Affect Phobia objectives and interventions have been used in the treatment of a 69-year-old married woman who reported “lifelong depression,” “misery” since early childhood and “countless” unsuccessful therapies over many decades. In clinical practice, the vast majority of Affect Phobias concern a few basic feeling categories (e.g., grief, anger/assertion, closeness, and positive feelings toward the self).

In the first 10 sessions in this treatment, dramatic change resulted from the exposure to feelings she had never felt in her 40 years of previous therapy. The therapist focused on compassion for herself, and grief over losses in her life. She was initially quite resistant and skeptical, but the therapist persisted, and by session 5, she no longer felt that she was a “bad seed.” She began to see that her perfectionist and critical parents had crippled her spirit early in her life. She reported crying in therapy for 40 years, but this was likely a helpless, hopeless, weepiness, and not a resolving grief process. In the early treatment sessions, the therapist focused on exposure to self-compassion as well as identifying her self-attacking defenses.

#### **Objective: Gain Insight into Maladaptive Patterns (Identify Defenses)**

Gaining insight refers to helping the patient become aware of unconscious defensive reactions as soon as they happen, and exploring their underlying feelings, origins in the past, and maintenance in current relationships

## Interventions

- A compassionate and collaborative therapist stance
- Regulating anxieties and shame associated with growing insight of defenses
- Validating defensive patterns as natural and once needed

*The therapist works with defenses beginning with a discussion on what it would be like to grieve in the session:*

- Patient* I am careful about my public personae. I am very aware of what other people might be thinking of me.
- Therapist* Let's try to look at that. We need to make you comfortable with all kinds of feelings. What might I be thinking of you if you came here and just cried your eyes out? (*The therapist uses the real relationship to help the patient face and bear her shame over expressing sadness.*)
- Patient* I don't know.
- Therapist* Can we sit with it for just a moment and see (*holding the patient on blocks to grief*).
- Patient* [tearful] I think it is because I have cried so much and it does not get me anywhere.
- Therapist* Yes, that would be frightening wouldn't it? (*compassionate and validating stance*)
- Patient* And [pause] I'll never stop, maybe (*anxiety about the grief*).
- Therapist* That fear is so common (*anxiety regulation – the therapist calms the patient's anxiety by normalizing the experience*). The problem is that people stick their toe in the pool of grief, get scared, and pull out (*validating defense*). They don't know to go through it and come out the other side. That is what I am here to help guide you through (*anxiety regulation – psycho education about the treatment process*).
- Patient* But I have been doing this for years [laughs].
- Therapist* And this is what keeps you in a chronic low-grade depression; it must be worked through (*identifying the costs of the defenses*).

## Objective: Relinquish Maladaptive Patterns (Response Prevention)

Identifying the costs of defenses will build motivation for their relinquishing.

## Interventions

- An active therapist stance
- Noting the costs of defenses
- Regulating anxieties associated with giving up

*The therapist begins to look more closely at the origins of defensive patterns, while gently challenging self-attacking belief systems and guiding the patient toward motivation for change:*

- Patient* I think . . . I was born with a kink loose somewhere.
- Therapist* There are clear things that I'm hearing with your feelings of perfectionism, and "never good enough" and so forth . . .
- Patient* Yes. "Something's wrong with me" [sighs].
- Therapist* Rather than "What was wrong with the situation under which you learned these habits?" (*anxiety regulation – challenging the self-attacking, shameful beliefs*)
- Patient* I guess I am rather moralistic. [pause] But other people have gone through greater odds and come out fine.
- Therapist* . . . Can you see how there's no compassion for yourself? (*continually identifying self-attacking defense*) No work will be done unless this [self attack] gets out of the way. On one hand you say, "There is something wrong with me," or "I was born with a kink loose," but you describe yourself as an intelligent and feisty child – who had parents holding you back. And that is just a tragic thing. (*The therapist attempts to elicit grief and self-compassion in the patient for her plight.*)
- Patient* they told me "The best was none too good."
- Therapist* Their moralistic and perfectionistic standards were laid on you, and can you see how you are holding on to them, tight! (*Confronting the defenses and identifying developmental origins*). We need to help you to treat yourself like you treat your grandchildren. What would you say to them if they make a mistake? (*Self-restructuring – changing perspectives to begin to improve her sense of self.*)
- Patient* I would be so gentle with them. . .but [pausing and covering face] . . .I am not worth it.
- Therapist* You are not worth it? Let's stay with that [pause]. What brings that pain right there? (*actively focusing on exposure to grief*)

*Patient* [Sobs with her face covered by her hands]. I don't know why I am not worth it. I really do believe that deep down there is something horrible in me. (*From the repeated therapist challenges, she begins to realize the destructiveness of her self-attack.*)

*Therapist* The issue that hovers around your life is this enormous lack of compassion for self that you have carried for all these years. (*Gently pointing out self attacking defenses.*)

*Although the patient moves closer to experiencing the grief associated with the costs of defenses, her self-attacking beliefs remain. Next, self-restructuring works to bring the patient closer to motivational stages, that is, readiness to begin facing core affect phobias.*

### **Objective: Restructure the Sense of Self (Build Strength for Affect Exposure)**

Through graduated exposure to positive feelings toward the self and adaptive feelings toward others, patients become increasingly able to bear conflicted affects.

#### **Interventions:**

- A compassionate therapist stance
- Identifying self attacking thoughts, feelings and behaviors
- Exposing patients to positive, compassionate feelings toward the self and from others, including the therapist.

*Continued . . .*

*Patient* I just can't imagine ever feeling good about myself.

*Therapist* If you had another woman sitting here, telling the story of her life and that she carried, for 65 years, that she was not a good person, what would you say to her? From your heart, what would you say? (*changing perspectives and exposure to compassionate self-feelings.*)

*Patient* [sigh] I would tell her "be yourself, your real self," and I would probably cry.

*Therapist* Tell me why you would cry for her (*focus on exposure to feeling of compassion.*)

*Patient* Because it is such a waste of life, think of all the waste [gazing off, silence].

- Therapist* What is going on for you now? What do you think I feel, seeing you, hearing this story today? (*exposure to the positive feelings of the therapist – Socratic questioning*).
- Patient* [looks away – *shame*] It feels very juvenile.
- Therapist* Very juvenile? How do you mean? (*focusing on continued self-attack*)
- Patient* My thought is, “Oh hell, grow up!”
- Therapist* You can see it intellectually and know you want to stop, but emotionally it’s hard (*a validating, compassionate stance*). Your emotions are conditioned patterns, like cigarettes or drinking, and needing reworking. (*The therapist then decides to change the patient’s perspective by using her own feelings.*) What do you sense that I am I feeling when I am hearing this story? (*actively focusing on exposure to therapist compassion – Socratic questioning*).
- Patient* Well, I hope you have a plan [laughs]. (*Response is intellectual rather than emotional.*)
- Therapist* Yes, that is in my mind. But, what is in my heart? (*Focusing on the feeling.*)
- Patient* I don’t know [looks down]. (*Defensive avoidance.*)
- Therapist* Can you let yourself go there for a moment? (*Holding focus on therapist compassion.*)
- Patient* My instinct is to say “what a wimp” [laughs nervously–*and attacks self-critically*].
- Therapist* You do not criticize this (*imaginary*) other woman, but instead, you turn the attack on yourself (*identifying self-attack*). And I will catch that every time. But, I just had a strong reaction toward you, and I want you to try to pick it up. What is in me? (*actively staying with exposure to therapist compassion – Socratic questioning. The therapist will not acknowledge her feelings, until the patient has searched within herself to sense the therapist’s response.*)
- Patient* [timidly] I hope sympathy?
- Therapist* You bet there is sympathy! (*Once offered, it is strongly supported.*) But not only that. . . I had this aching feeling thinking about it, and it is heartache (*shared affect*). The word. . . heartache came up. A little bit of tears, a real sad feeling in my body (*modeling identification of feelings*). Yet I am not living what you are going through. It is a real tragedy how you have suffered all your life, and there is that grief in you somewhere about these losses. I am going to shine a spotlight on it, and you can too, until you can’t bear to hurt yourself any longer. How does that sound?
- Patient* [with a slight raising of the eyes] . . . Hopeful.

*The process of restructuring defenses and feelings toward the self often takes time and repetition depending on the intensity of the presenting conflicts, the rigidity of the patient's defenses, and the degree of the patients strengths. In this case, the work of actively and consistently desensitizing her phobias to grief and self-compassion began within the first five treatment sessions. The carefully considered use of therapist feelings has been a powerful tool to impact on sense of self. We learn who we are from others responses to us.*

### **Objective: Exposure to activating affect with graduated intensity (Exposure)**

The therapist draws from Gestalt and experiential strategies as well as from a variety of cognitive, behavioral, and psycho-educational interventions employed in step-wise desensitization in doses that the patient can bear.

### **Interventions**

- Active therapist stance
- Graduated exposure to feared affect in imagery, memory or fantasy
- Focus on emotional experiencing in bodily arousal
- Preventing defensive avoidance (“Stay with the feeling in your body”)
- Modulate anxieties (“What’s the hardest part of feeling the grief?”)

*Session 10: Here, the therapist guides the patient in grieving the losses of childhood – the loss of nurturance and parental compassion.*

- |                  |  |
|------------------|--|
| <i>Patient</i>   | I am sad. So damn it, I want to work this out, get over it. <i>(She has become highly motivated.)</i>  |
| <i>Therapist</i> | Just stay with that <i>(encouraging exposure to feeling)</i> .   |
| <i>Patient</i>   | [struggling] I can't [pause]. I really can't. . .[trailing off]  |
| <i>Therapist</i> | Just try to stay with your body <i>(preventing defensive avoidance and connecting emotional and bodily arousal)</i> . What hurts the most? <i>(anxiety regulation)</i> . |
| <i>Patient</i>   | My body [points to her heart].   |
| <i>Therapist</i> | Your heart hurts most? So let's help you sit with the grieving. <i>(Giving support)</i>  |
| <i>Patient</i>   | I don't want to stay with the grieving. <i>(A phobic response to the feeling)</i>  |
| <i>Therapist</i> | What is hardest about it? <i>(Anxiety regulation is used to help her stay with the feeling by exploring her fears about the feeling.)</i>                                |

- Patient* It is just such a familiar path. And it comes again, and again, and again [tears up].
- Therapist* Yes, well let's go with it for a little bit (*response prevention – holding patient on the grief*). Your eyes water and there is so much pain in you right now. [softly] Will you let me look at it with you?
- Patient* [sighs] I don't know what to do with it.
- Therapist* Let's put some words on it for a moment. What are you feeling that could speak for that hurt heart? (*helping patient to label the experience*).
- Patient* It feels like I want my mama; that is what it feels like.
- Therapist* Yes, right.
- Patient* It is so sad [tears up].
- Therapist* Let yourself float back, way back then (*exposure to grief through imagery*). What ever comes, what memories come? "I want my mama." It is such a deep part of all of us. What did you long for most from her? (*continues imagery of longing for her mother*).
- Patient* [tearful] Hugs [And she begins to cry].

*The process is best characterized by graduated steps, the Grandmother's "toe is dipped in the waters of grief." Affect work is often characterized by brief moments of affect followed by defense restructuring and anxiety regulation. Later, the patient experiences a much fuller and deeper grieving process as described below. Successful resolution of affect phobias typically involves much repletion of the same affect-laden images.*

- Therapist* Let's imagine that she could love you (affect exposure – *imagining the action tendency*). Let's create an ideal mother.
- Patient* She would just hold me.
- Therapist* And how would she hold you? (*affect exposure – provide rich detail to images*).
- Patient* Just hug me, I guess [looks down].
- Therapist* Are you kind of detached from this part? (*pointing out defensive resistance*).
- Patient* Yes, I can't possibly imagine that happening in real life.
- Therapist* But right now see if you can imagine an ideal mother (*affect exposure – holding patient on focus of receiving care for self*).
- Patient* [sighs] So a real mother would have put her arms around me and told me that it was going to be all right?
- Therapist* And she would have rubbed you a little bit and held you tight? And how would that make you feel to have somebody there saying that?

- Patient* [with a sad voice] That would feel so good.
- Therapist* Yes, how does it feel in your body if you really let yourself go deep into that (*connecting image to bodily experience*)? She is holding you; she might be resting her head on your head. Stroking your hair. Where do you feel it in your body?
- Patient* [starts to cry deeply]
- Therapist* Just stay with that. [silence, patient crying]
- Patient* It makes my heart ache [covers eyes and sobs]. I have never felt so alone. [sobs deeply] . . . I think I am still grieving the loss of a mother I never had.

*This session was rated on the ATOS, Her level of experiencing of grief was in the high 70's, ebbing and flowing for over 40 min. Her level of inhibitory feeling was in the 70–80 range (her great pain over the profound neglect in childhood, and her shame about herself.) She continued the grief process until the shame and pain were reduced and she felt a more compassionate, and accepting stance toward herself. The adaptive grief she was exposed to resulted in a lifting of her depression, discontinuance of her antidepressant medication, and as best described in the following examples, a new way of experiencing herself and the world.*

- Patient* My daughter came to visit and she said, “Mom! You’re better!” “You’re really better!”
- Therapist* So what do you think is the shift?
- Patient* The depression lifting.
- Therapist* What do you think made the depression lift? What aspect of what we did?
- Patient* I got deeper into what was reality, instead of telling the same old story of complaining and feeling sorry for myself. You did not let me get away with that [laughs].
- Therapist* What was the same old story?
- Patient* You know, that I was constantly criticized and never fully praised. (*This patient spent 30+ years in therapy telling the “same old story!” She knew what was wrong; the intellectual stories were told, but she had never focused so intently on the associated feelings.*)
- Therapist* What did we do different here?
- Patient* We went deeper. You did not let me off the hook.

*Finally, here in a discussion of her day*

- Patient* I was early, so I drove a different route. While driving, I thought how beautiful everything looks. The houses are wonderful, the sun is wonderful, spring is coming and [pause]. It is different; I really am different!

*At one and a half year follow-up she was able to maintain these gains and stay off antidepressant medication. She then had many crises in the coming years, including her husband's increasing illness, and a tragic death of an adult child, but she coped better than expected, and throughout the difficulties, never again felt herself to be a "bad seed."*

## Conclusion

It has been said repeatedly that research does not influence clinical practice. However, this treatment model has been developed and repeatedly revised, always closely guided by research findings. Research has been the architect as well as the demolition squad of the affect phobia treatment model. The data has often challenged us in unexpected ways but remembering that "the data is our friend" has guided us well and led to a more nuanced understanding of underlying processes.

Twenty-five years of process research has pointed us to affect as the primary change agent in short-term psychotherapy; possibly stronger than insight or motivation for treatment, and now, some forms of affect restructuring may be, in some instances, a stronger factor than the therapeutic alliance. If we improve our therapeutic skills, the affect variables may capture more variance and may challenge the alliance factor even further. These results suggest that the interventions taught in this chapter can be said to be evidence-based, and may lend support to specific factors at work in short-term psychotherapy.

Finally, emerging therapists or seasoned clinicians can feel more confident that the empirical evidence is pointing to feeling as a prime focus in for resolution of patient symptoms, interpersonal problems, and character pathology. So:

*Don't forget to follow the affect!*

## References

1. Wampold, B. (2001). *The great psychotherapy debate*. New Jersey: Lawrence Erlbaum.
2. Lambert, M.J. & Ogles, B.M. (2004) Chapter 5. The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th edition), New York: John Wiley & Sons, Inc., 139–193.
3. Malan, D.M. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Heineman-Butterworth Press.
4. Davanloo, H. (Ed.) (1980). *Short-term dynamic psychotherapy*. New York: Jason Aronson.
5. Davanloo, H. (1988). The technique of unlocking of the unconscious: Part I. *International Journal of Short-Term Psychotherapy*, 3(2), 99–121.
6. McCullough, L. (1991). Davanloo's short-term dynamic psychotherapy: A cross-theoretical analysis of change mechanisms. In R. Curtis & G. Stricker (Eds.), *How people change: Inside and outside of psychotherapy*. New York: Plenum Press, 59–79.
7. McCullough, L. (1999). Short-term psychodynamic therapy as a form of desensitization: Treating affect phobias. *In Session: Psychotherapy in Practice* 4(4), 35–53.

8. McCullough, L., Kuhn, N., Andrews, S., Kaplan, A, Wolf, J. & Hurley, C.L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. New York: Guilford Press.
9. Foa, E. and Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin* 99(1), 20–35.
10. Freud, S. (1956). Turnings in the ways of psychoanalytic therapy. In E. Jones (Ed.), *Collected Papers*, Vol. 2, London: Hogarth Press, 392–402.
11. Alexander, F. & French, T.M. (1946). *Psychoanalytic therapy: Principles and applications*. New York: Ronald Press.
12. Malan, D.M. (1963). *A study of brief psychotherapy*. New York: Plenum.
13. Stern, D.N. (1995). *The motherhood constellation*. New York: Basic Books.
14. Stern, D.N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
15. Stern, D.N. (1977). *The first relationship: mother and infant*. Cambridge, Mass.: Harvard University Press.
16. Tomkins, S.S. (1962). *Affect, imagery, and consciousness: Vol. I. Positive affects*. New York: Springer.
17. Tomkins, S.S. (1963). *Affect, imagery, and consciousness: Vol. II. Negative affects*. New York: Springer.
18. Ekman, P. & Davidson, R. (1994). *The nature of emotion*. New York: Oxford University Press.
19. Eagle, M. (1984). *Recent developments in psychoanalysis. A critical analysis*. New York: McGraw Hill.
20. Cautela, J.R. (1977). Covert conditioning: Assumptions and procedures. *Journal of Mental Imagery*, 3, 53–64.
21. Cautela, J.R & McCullough L. (1977). Covert conditioning: A learning theory perspective on imagery. In J.L. Singer & K.S. Pope (Eds.) *The power of the human imagination*. New York: Plenum Press, 227–254.
22. Dollard, J. & Miller, N.E. (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking, and culture*. New York: McGraw-Hill.
23. Stampfl, T.G. & Levis, D.J. (1967). Essentials of implosive therapy: A learning-theory based psychodynamic behavioral therapy. *Journal of Abnormal Psychology*, 72, 496–503.
24. Feather, B.W. & Rhoads, J.M. (1972). Psychodynamic behavior therapy: II: Clinical aspects. *Archives of General Psychiatry*, 26, 503–511.
25. Freud, S. (1923). The Ego and the Id. *Standard Edition*, 19, 2–66.
26. Wachtel, P.L. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York: Basic Books.
27. Orlinsky, D.E., Ronnestad, M.H. and Willutzki, U. (2004). Fifty Years of Psychotherapy Process-Outcome Research: Continuity and Change. In Michael Lambert (Editor) *Bergin and Garfield's handbook of psychotherapy and behavior change: (5th Edition)*, New York: John Wiley & Sons, 307–390.
28. Orlinsky, D., Grawe, K. & Parks, B.K. (1994). Process and outcome in psychotherapy – noch einmal. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change (4th edition)*, New York: John Wiley & Sons.
29. Gray, J.A: (1975). *Elements of a two-process theory of learning*. New York: Academic Press.
30. Fowles, D.C., (1980). The three arousal model. Implications of Gray's two-factor learning theory for heart rate, electrodermal activity, and psychopathy. *Psychophysiology*, 17(2), 87–104.
31. Fowles, D.C. (1988). Psychophysiology and psychopathology. A motivational approach. *Psychophysiology*, 25(4), 373–391.

32. Wilhelm, F.H. & Roth, W.T. (1998). Taking the laboratory to the skies: Ambulatory assessment of self-report, autonomic, and respiratory responses in flying phobia. *Psychophysiology*, 35(5), 596–606.
33. Konorski, J., (1967). *Integrative activity of the brain: An interdisciplinary approach*. Chicago: University of Chicago Press.
34. Dickinson, A. & Dearing, M.F. (1979). Appetitive-aversive interactions and inhibitory processes. In: A. Dickinson & Boakes, R.A. (Eds.) *Mechanisms of learning and motivation*. Hillsdale, NJ: Erlbaum, 203–231.
35. Lang, P., P.J., Bradley, M.M. & Cuthbert, B.N: (1998). Emotion, motivation, and anxiety: Brain mechanisms and psychophysiology. *Biological Psychiatry*, 44: 1248–1263.
36. Sutton, S.K. & Davidson, R. (1997). Prefrontal Brain Asymmetry: A biological substrated of the behavioral approach and inhibition systems. *Psychological Science*, 8, 204.
37. Foa, E. & McNally, R.J. (1996). Mechanisms of change in exposure therapy. In R. M. Rapee (Ed.), *Current controversies in the anxiety disorders*. New York: The Guilford Press, 229–343.
38. Barlow, D.H. (Ed.) (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: The Guilford Press.
39. Winston A, McCullough L, Trujillo M, Pollack J, Laikin M, Flegenheimer W & Kestenbaum, R. (1991) Brief psychotherapy of personality disorders. *Journal of Nervous and Mental Disease*, 179(4), 188–193.
40. Winston, A., Laikin, M., Pollack, J., Samstag, L.W., McCullough, L. & Muran, J.C. (1994). Short-term psychotherapy of personality disorders. *American Journal of Psychiatry*, 151(2), 190–194.
41. Svartberg M., Stiles, T. & Seltzer, M. (2004). A randomized controlled trial of the effectiveness of short term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. *Journal of Consulting and Clinical Psychology*, 161, 810–817.
42. Derogatis, L.R. (1983). *SCL-90-R: Administration, scoring & procedures manual-II for the revised version and other instruments of the psychopathology rating scale series* (2nd edition). Towson, MD: Clinic Psychometric Research.
43. Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno, G. & Villasenor, V.S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of Clinical and Consulting Psychology*, 56, 885–892.
44. Millon, T. (1984). *Millon clinical multiaxial inventory* (3rd edition). Minneapolis, MN: National Computer Services.
45. McCullough, L., Larsen, A.E., Schanche, E., Andrews, S., Kuhn, N., Hurley, C.L., et al. (2004). *Achievement of therapeutic objectives scale*. Short-Term Psychotherapy Research Program at Harvard Medical School. Can be downloaded from [www.affectphobia.com](http://www.affectphobia.com).
46. Carley, M. (2006). *The validity of the achievement of therapeutic objectives scale*. Dissertation. Fielding Institute. Boston, MA, 2006.
47. Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale, NJ: Lawrence Erlbaum.
48. Leichsenring, F., Rabung, S. & Leibing, E. (2004). The Efficacy of Short-term ppsycho-dynamic psychotherpay in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry*, 61, 1208–1216.
49. Salerno, M., Farber, B., McCullough, L., Winston, A. & Trujillo, M. (1992). The effects of confrontation and clarification on patient affective and defensive responding. *Psychotherapy Research*, 2(3), 181–192.
50. Makynen A. (1992). The effects of continued confrontation on patient affective and defensive response. Columbia University Teachers' College, May, 1992. *Dissertation Abstracts International*, 54-01B.
51. Foote, J. (1989). Interpersonal context and patient change episodes. New York University, May, 1989. *Dissertation Abstracts International*, 51-12B.

52. Joseph, C. (1988). Antecedents to transference interpretation in short-term psychodynamic psychotherapy (doctoral dissertation, Rutgers University). *Dissertation Abstracts International, May 1988 50-04B*.
53. Porter, F. (1988). The immediate effects of interpretation on patient in-session response in brief dynamic psychotherapy. Columbia University Teachers College, May, 1987. *Dissertation Abstracts International, 48, 87-24076*.
54. McCullough L., Winston A., Farber B., Porter F., Pollack J., Laikin M., Vingiano W. & Trujillo, M. (1991). The relationship of patient-therapist interaction to outcome in brief psychotherapy. *Psychotherapy, 28(4), 525-533*.
55. Taurke, E., McCullough, L., Winston, A., Pollack, J. & Flegenheimer, W. (1990). Change in affect-defense ratio from early to late sessions in relation to outcome. *Journal of Clinical Psychology, 46(5), 657-668*.
56. Coombs, M.M, Coleman, D. & Jones, E.E. (2002). Working with feelings: The importance of emotion in both cognitive-behavioral and interpersonal therapy in the NIMH Treatment of Depression Collaborative Research program. *Psychotherapy: Theory/Research/Practice/Training, 39(3), 233-244*.
57. Goldfried M.R., Raue P.J. & Castonguay, L.G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66, 803-810*.
58. Ablon, J.S. & Jones, E.E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive behavioral therapy. *Psychotherapy Research, 8, 71-83*.
59. Ablon, J.S. & Jones, E.E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67, 64-75*.
60. Ablon, J.S. & Jones, E.E. (2002). Validity of Controlled Trials of Psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. *American Journal Psychiatry, 159, 775-783*.
61. Diener, M.J., Hilsenroth, M.J. & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 164, p 936-941*.
62. Ferenczi, S. and Rank, O. (1925). *The Development of Psychoanalysis*. New York: Nervous and Mental Disease Publishing Company.
63. Carver, C.S. and White; T.L. (1994). Behavioral inhibition, Behavioral Activation, and Affective Responses to Impending Reward and Punishment: The BIS/BAS Scales. *Journal of Personality and Social Psychology, (1994), 67, 319-333, content.apa.org*.
64. Horvath, A.O. and Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36, 223-233*.