Short Term Dynamic Psychotherapy Goes to Hollywood: The Treatment of Performance Anxiety in Cinema

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This article uses characters in popular films to demonstrate the theory and application of short term dynamic psychotherapy (STDP) in the treatment of performance anxiety. The reader is taught to identify affect phobias that are hypothesized to underlie performance anxiety. Similar in function to external phobias, affect phobias or internal phobias involve the avoidance of feelings (e.g., fear about feeling anger, shame about showing grief, pain about closeness), which thwarts adaptive responding and generates numerous behavioral problems. STDP treatment focuses on the restructuring of defenses, conflicted affects, and attachments. The resolution of the affect phobia requires systematic desensitization of affective responses (i.e., exposure and desensitization of underlying conflicted feelings). When patients learn to access adaptive forms of feelings, performance anxiety can often be resolved. © 2004 Wiley Periodicals, Inc. J Clin Psychol/In Session 60: 841–852, 2004.

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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).

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In the British comedy *Four Weddings and a Funeral*, Father Gerald is a priest who has performance anxiety and 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 Spiggot . . . uh, Spirit." Father Gerald has performance anxiety. And it is bad!

Broadcast News is another film that vividly portrays performance anxiety. During a live broadcast, the news anchor drips with sweat, turns pale, and smacks 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—mutters 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 trifle 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 short term dynamic psychotherapy (STDP) treat this all too common problem? In this article, we first describe the basic concepts of STDP then use film characters 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. Questions include the following: Are there other existing Axis I and Axis II diagnoses? What are 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 of defenses, affects, and attachments

Affect phobia refers to the feeling that is avoided. The two triangles describe the way 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 Phobia

Most people are familiar with external phobias: the fear and avoidance, for example, of 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 undeserving to feel adequate self-esteem.

Performance anxiety might seem to be an external phobia—the fear of standing up in front of other people. But as do 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 focus 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 in order to be able to not be anxious about performance.

In this article we generate hypotheses about affect phobias and defensive patterns used by each of the film characters. But first we describe the two triangle schema, which puts these affect phobias in context.

Two Triangles

David Malan, 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. These organize and operationalize what happens, and with whom, when intrapsychic conflict develops and phobic affects result.

As shown in Figure 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).

Such defenses may have been adaptive and useful at some time, but they become destructive when they result in maladaptive behaviors. The STDP therapist is vigilant in pointing out how these defensive patterns are serving to avoid feelings.

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, insufficient inhibition can result in sociopathy or psychopathy. Excessive inhibition can be crippling, as in the news anchor’s withdrawing 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 he or she is using inhibitory feelings.

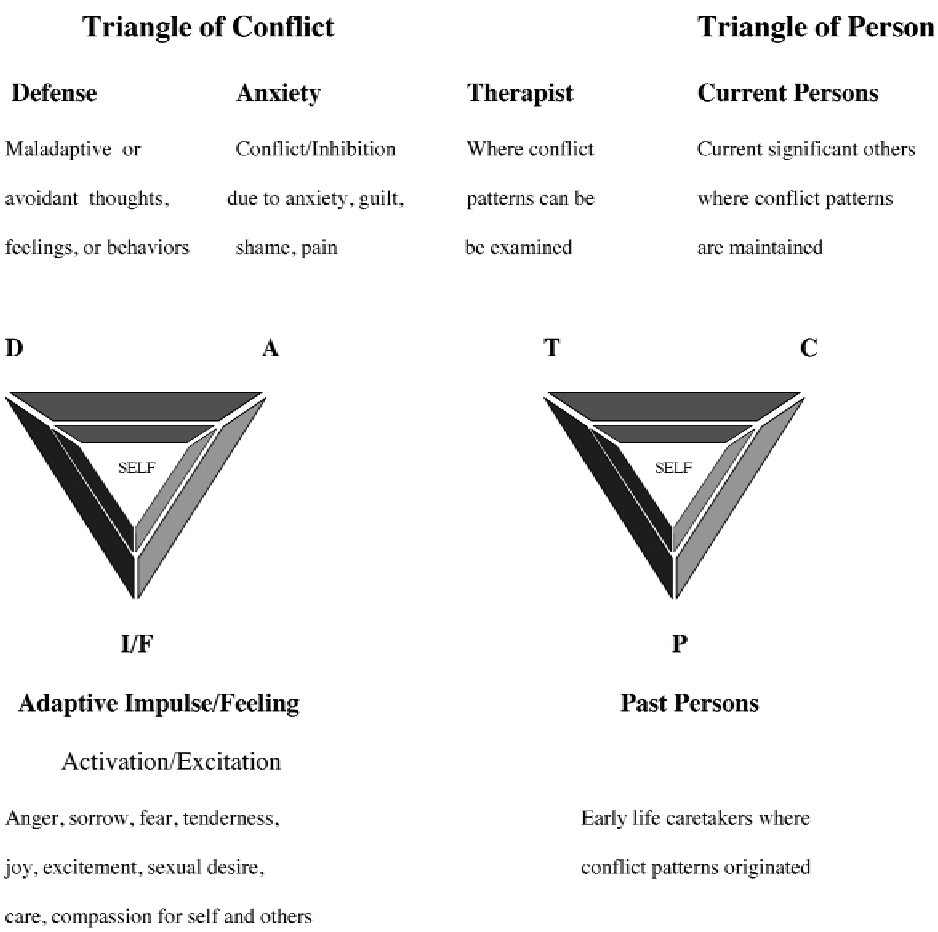

Figure 1. An adaptation of Malan's two triangles for treating affect phobias.

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. As shown in Figure 1, these patterns can originate in past relationships (P), continue in current relationships (C), and be played out in the relationship with the therapist (T).

Indeed, affect phobias are typically learned in early childhood from caretakers and 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, withdraw, 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. The two triangle schema provides an example.

THERAPIST: Father Gerald, can you see that your anxious behavior in church (D) as well as with me (T) is similar to the way you responded last week to the bishop (C)? This pattern seems to have begun when you tried hard 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 in use of maladaptive defenses); affect restructuring (exposure to the "true" but phobic feeling); self–other restructuring (improvement in sense of self and relationship with others); and anxiety regulation (decrease in 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 writes (1988, p. 312):

> 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 these techniques.

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 require resolution in order to restructure defenses properly. The patient has to be able to recognize and understand the defensive patterns and be motivated to relinquish them. 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, in order 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 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 must 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 feeling(s) would help Father Gerald overcome his performance anxiety at the wedding? What feeling(s) 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 question by eliciting further information from the patient. Close attention is paid to the nonverbal and verbal responses to feelings. The therapist and patient begin to link the anxieties and defenses, moving closer to uncovering the actual blocked feeling and its origins. We hypothesize about the film characters but use our clinical experience with actual patients to develop their stories.

Father Gerald's Affect Phobia

Let us imagine that Father Gerald has contacted a STDP therapist, concerned that he has done poorly in previous ceremonies, and is becoming increasingly anxious, and that anxiety is making his problem 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 by 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 your father had.

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 to another colleague. Therefore, he is well aware that he feels jealous, angry, and devalued but is still unable to negotiate a better contract.

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 whether 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 I am not good enough and am faking it and am going to be found out.

This answer 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 examined.

Anxious Suitor's Affect Phobia

The STDP therapist might hypothesize that the anxious suitor lacks self-confidence or sufficient self-esteem in his relations 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 matters worse, he had been cruelly teased by his sisters while growing up and never wants to let himself be seen as who he is.

What emotions does he need to access to master this situation? Obviously he needs to develop healthy self-esteem and self-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 responses? 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 for the film characters:

THERAPIST (to Father Gerald): What is the most shameful thing about not perfectly performing vows?

THERAPIST (to news anchor): Can we look at what it is about public performance that is the most terrifying for you?

THERAPIST (to anxious suitor): What is the most painful part of being rejected by a woman? (He might possibly also need to grieve the loss of closeness in his early life but feels too afraid and ashamed. Some patients have more than one of these inhibitory feelings working in concert to thwart adaptive feeling or action; some have only one or two. The anxious suitor seems to have a good number of them.)

Exploring 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 (develop an observing ego) to help him or her better cope with fears.

Although these film characters are fictitious, their behaviors and our interpretations of their underlying problems reflect typical problems in treatment that STDP conceptualizes by 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 he is a fake (D), and is not entitled (A) to fight hard (F) for what he wants in his contract. He would need to build strong self-esteem and self image (F—positive feelings associated with the self) and become comfortable with appropriate expressions of anger and 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, become unafraid to be close (F) to others, and probably also feel grief (F) and anger (F) toward 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 would begin 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 treatment by both the patient and the therapist. We can never know whether the hypotheses are correct or historically accurate. We can only hope that the hypothesis is accurate 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 to ensure that change will 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 exposure and response prevention provide the most effective treatment for a phobia. STDP treatment has similar premises: Effective treatment involves exposure to the phobic feelings to reduce the inhibitory feeling that prevents these feelings from being properly expressed.

Similarly to a behavior therapist's 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. Similarly 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 of the process of desensitization of affects. First is to prevent the defensive response by pointing out avoidance and refocusing the patient. Second is to expose the patient to the phobic affect, guiding the patient him or her to experience the feeling on a visceral level in order for behavior to change; Gestalt techniques are very useful here. Third is to reduce the associated inhibitory affects (anxiety, guilt, shame, pain); cognitive techniques are excellent for dealing with these affects.

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 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 can help Father Gerald face that he is not yet as inspiring in his performance as he would hope. This fact should elicit some sorrow for himself 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 of and compassionate (F) to himself.

THERAPIST: What do you think the congregation is thinking of you when you mix up your words?

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

THERAPIST: 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 toward 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 whether 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 in which 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 5 to 10 sessions.

In the case of the news anchor 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 that his needs 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 in order to be effective and may begin with small and tolerable doses. The process starts with the patient's describing a specific troublesome incident in vivid detail, as if it were really happening in the moment, to help him or her to access and experience the emotions associated with the scene.

The process might involve interactions such as the following:

THERAPIST: You mentioned how difficult it is for you to negotiate for yourself. Could you imagine being back in the boss's 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 let that angry energy out on your boss? Can you let yourself feel that? [exposure 1]

NEWS ANCHOR: I hate acting like a bully. I never want to do that! [shame associated with anger]

THERAPIST: We are not 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 angry feelings that are part of your life force? [therapist refocus on the phobic affect for exposure 2]

NEWS ANCHOR: 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 employ a stepwise and supportive manner. In this case, the therapist helps the news anchor feel a little irritation before he can 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 than the other two characters have. 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, he or she often can access the feeling if it is one step removed, as Father Gerald did. 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 she loved having me around. [tears beginning to flow] No one else in my family made me feel that way.

THERAPIST: I wonder whether you could hold onto 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 exposures for the anxious suitor, must be repeated until shame is decreased and replaced by healthy pride: "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 to 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 of 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 embedded in the triangle of conflict, the STDP therapist helps the patient develop a hypothesis concerning how he or she avoids feelings (defenses), why he or she is avoidant (anxieties), and what he or she is avoiding (the true or phobic affect). Thus the two triangles become operational by answering these questions, which then guide the STDP interventions.

The common factors of 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 the patient can learn to articulate his or her experience, and gives encouragement to help the patient face fears and continue to practice repeated exposure to fearful and conflicted feelings.

This model of STDP has been developed and refined through research findings over the past 25 years. In addition to research supporting the efficacy of the common factors incorporated in STDP, two randomized, controlled clinical trials have supported the efficacy of this model. The first clinical trial (Winston et al., 1991) and 2-year follow-up (Winston et al., 1994) as well as a series of process studies (e.g., McCullough et al., 1994; Salerno et al., 1994; Makynen, 1994; Foote, 1989) were conducted at Beth Israel Medical Center in New York City. The second clinical trial and 2-year follow-up were conducted at the University of Trondheim in Norway, comparing STDP with cognitive therapy (Svartberg, Stiles, & Seltzer, 2004). Currently, a large-scale process study is under way at the Norwegian University of Science and Technology in Trondheim, where the videotapes of these clinical trials are being extensively analyzed for change mechanisms that promote improvement (e.g., McCullough et al., 2004; Valen, McCullough, Stiles, & Svartberg, 2003; Johansen et al, 2004) and compared to change mechanisms in videotapes from other theoretical orientations such as dialectical behavior therapy (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 be less 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 a life that is 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 when she was alive), nevertheless recognized the 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.
> The Heroism we recite
> Would be a normal thing
> Did not ourselves the Cubits warp
> For fear to be a King.

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