Introduction

STDP and Affect Phobias

The aim of this book is to teach you how to do **Short-Term Dynamic Psychotherapy (STDP)** by focusing on **Affect Phobias**. STDP is an active, time-efficient, focused, integrative form of treatment that has resulted in significant and lasting character change for many patients, even ones who have failed to benefit from extended therapies of other types.

Skills Focus

Although "step-by-step" instructions are too rigid for a process as rich as STDP, this book will help you acquire a set of skills that will make your therapy more powerful and effective. Most readers will find that some of these skills seem comfortable and familiar, while other skills may seem alien and challenging. There is a growing body of research evidence and clinical experience indicating that, taken together, these skills constitute a highly effective model of psychotherapy.

Exercises Enhance Procedural Knowledge

We believe that doing therapy—as opposed to talking about it—is based more on skills (i.e., **procedural knowledge**) than on ideas (i.e., **declarative knowledge**). To help you acquire those skills, we have included exercises at the ends of the first 10 chapters, which we strongly encourage you to do. However, exercises are not to everyone's taste, and if these aren't to yours, you can skip some or all of them. You won't be missing any "new concepts," but some of the material is clarified, and there are opportunities to build skills.

Changing Character

This book originated as a companion volume to *Changing Character: Short-Term Anxiety-Regulating Psychotherapy for Restructuring Defenses, Affects, and Attachment* (McCullough Vaillant, 1997; referred to from now on as *Changing Character* or just CC). Our aim here is to help the reader acquire the skills necessary to do the therapy that is discussed in more theoretical depth in the earlier work. To that end, there are extensive references to *Changing Character* throughout this book, and readers who are looking for a fuller discussion of many points here will be able to pursue them in that volume. In addition, our thinking has evolved since *Changing Character* was written, particularly in bringing the concept of Affect Phobia—which is present but not emphasized in CC—to the forefront.

Research Evidence

This treatment model has been developed and repeatedly revised on the basis of both clinical observations and research findings. The work of Malan and his colleagues, has provided us with a 50-year careful study of "the science of psychodynamics" as applied to brief psychotherapy. More recently, there have been two clinical trials that have demonstrated the efficacy of STDP for patients with Axis II, Cluster C, diagnoses. The first took place at Beth Israel Medical Center in New York City from 1982 to 1990 (Winston et al., 1991, 1994). The second trial, conducted at the Norweigan University of Science and Technology (NTNU) in Trondheim, Norway, from 1988 to 1999, compared this model of STDP with a cognitive therapy model (Svartberg, Stiles, & Seltzer, in press). There are also many process studies showing the importance of the affect and defense work covered in this book (for a summary, see Ch. 12 of CC). Research on this therapy continues at Harvard Medical School and NTNU.

Integration of Psychodynamic Theory and Learning Theory

This therapy is based on the idea that much psychopathology is rooted in **Affect Phobia**—a fear of feelings. The concept of Affect Phobia is a recasting of the concept of psychodynamic conflict into the language of learning theory and behavioral therapy. The result is that the well-established techniques and concepts of phobia treatment (e.g., systematic desensitization) can be brought to bear on psychodynamic issues in a way that helps to focus STDP and avoid common pitfalls.

Affect Phobias Extend the Freudian Dual-Drive Model

Most patients will have one or more central Affect Phobias (which we also refer to as **core psychodynamic conflicts**), which lead them into the difficulties they experience. These Affect Phobias can be centered around not only sex and aggression (as classical Freudian conflict theory would suggest), but around any of the fundamental human affects. In clinical practice, the vast majority of Affect Phobias center around a few basic feeling categories—for example, grief, anger (which includes healthy assertion), closeness, and positive feelings toward the self.

Part I of the Book: Introductory Material

Part I of this book consists of four chapters of introductory material. We introduce affect and list the basic affects in Chapter 1. These include activating affects such as grief or anger/assertion, and inhibitory affects such as anxiety or shame. We then go on to introduce Affect Phobia and the central concept of **anxiety regulation**—the key to keeping an active, focused therapy from feeling too "confrontational" to the patient.

Chapter 2 shows how Affect Phobia can be viewed, in psychodynamic terms, as a triangular constellation of defenses and inhibitory affects that block adaptive feelings. Defensive behaviors (e.g., passivity, avoidance, self-attack) allow the patient to avoid the conscious experience of conflict between an adaptive affect (e.g., assertion/anger) and the inhibitory affect that goes with it (e.g., anxiety or shame over being rejected). One of the critical skills for doing this therapy is to be able to identify these key components of Affect Phobias **as the patient is speaking**. The exercises at the end of Chapter 2 should help you start to acquire this ability.

The central **therapeutic** implication of the Affect Phobia schema is that psychodynamic conflict can be treated in a way that is analogous to standard phobia treatment: by **systematic desensitization**. This means helping patients gradually to experience more and more adaptive affect, while helping them keep their anxiety or other inhibitory affects at a manageable level.

Chapter 3 introduces the assessment process and shows how the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) multiaxial diagnostic system—particularly the Global Assessment of Functioning (GAF) Scale—helps in deciding whether short-term treatment of Affect Phobia is appropriate for the particular patient sitting in your office.

Part I closes with Chapter 4, which will teach you the nuts and bolts of how to make an Affect Phobia **formulation**—that is, how to work with the patient to identify the triangles of defense, adaptive affect, and inhibitory affect introduced in Chapter 2.

Case Example

We believe that the best—perhaps the only—way to learn psychotherapy is through specific examples. In that spirit, we will illustrate these concepts and introduce the remainder of the book by using the example of a fictional patient, a 37-year-old woman who works as an administrative assistant.

The therapy starts from a specific problem:

Starting from a Specific Problem

THERAPIST: Could you tell me what's the main problem that brought you into therapy?

PATIENT: I don't know. I just seem to be depressed all the time.

THERAPIST: Can you give me an example of something that depresses you?

PATIENT: I don't know, there are so many . . . well, my boss came in yesterday and gave me a whole new stack of work. I still haven't finished the last stack he gave me. I'm working like a dog, but he never seems to notice, and I just feel like I'll never even catch up.

Identifying the Underlying Affect Phobia

Even after an exchange as brief as the one above, the therapist will begin tentatively formulating an Affect Phobia underlying the patient's problem. In this case, the patient's immediate association is to feeling overwhelmed by her boss's expectations. Perhaps she experiences a phobia that centers around assertion and setting limits with her boss on how much she can be expected to do. Her depression may then be an Affect Phobia about assertion that results in "anger turned inward." The therapist can test this hypothesis:

Checking Out the Phobic Response

THERAPIST: Have you told him that you can't start something new if he wants you to finish up the work he's already given you?

PATIENT: Oh, I couldn't do that . . . he's really been good to me. I thought

about doing that, and that's when I started to feel really bad, like I'm lazy and won't amount to anything. I couldn't bear to disappoint him.

By asking these questions about assertion, the therapist starts to see how phobic the patient is of this healthy, adaptive response. The therapist has also started to elicit examples of behaviors on the patient's part that may serve as defenses against assertion. In this case, the patient is using a number of defenses: She's being passive, she's idealizing her boss, and she's attacking herself.

Exploring Anxieties Causing the Affect Phobia

The therapist can also start to explore the Affect Phobia—that is, the inhibitory affects (anxieties) centering around assertion:

THERAPIST: What would be the hardest thing about just telling him he that needs to choose between finishing up or starting something new?

PATIENT: I'd be afraid that he would get angry at me.

Of course, this fear may be justified or it may be a projection, and more exploration will be needed. Nevertheless, the therapist is beginning to uncover some anxieties.

Parts II and III of the Book: Treating Affect Phobia

Parts II and III (Chapters 5–10) are devoted to the treatment of Affect Phobia. To organize the treatment, it has been broken down into three primary treatment objectives, each of which has two components. Each of these six components is covered in a separate chapter.

- **Defense Restructuring** (Defense Recognition, Chapter 5, and Defense Relinquishing, Chapter 6): identifying and giving up phobic behavior.
- **Affect Restructuring** (Affect Experiencing, Chapter 7, and Affect Expression, Chapter 8): reducing the fear about experiencing and expressing conflicted affect.
- **Self- and Other-Restructuring** (Self-Restructuring, Chapter 9, and Other-Restructuring, Chapter 10): changing the view of self and others.

Part II (Chapters 5–8) covers Defense Restructuring and Affect Restructuring, which can be thought of as "the basics" in STDP. With patients who are more impaired, there may be a need to start almost exclusively with Self- and Other-Restructuring, as covered in Part III (Chapters 9 and 10).

Defense Recognition: Identifying the Affect Phobia

Defense Recognition, covered in Chapter 5, helps patients recognize their phobic avoidance of adaptive feeling. Let us return to our example:

THERAPIST: You've told me a couple stories where people want burdensome things from you and you go along with them [defense of passivity], because it made you too anxious [inhibitory feeling] to set any kind of

limits [activating feeling: assertion/anger]. Is that a general pattern with you?

PATIENT: Oh, boy, is it ever!

Chapter 5 explores a number of techniques for helping patients to recognize their defensive behaviors on their own. Many techniques from this chapter will be familiar to psychodynamic therapists: clarification, interpretation, and others.

Defense Relinquishing: Giving Up the Maladaptive Response

As any psychodynamic therapist can tell you, intellectual insight into defenses and the desire and readiness to change them are quite separate issues. Defense Relinquishing, the topic of Chapter 6, aims to help increase the patient's motivation to give up their defenses. Its chief tool is anxiety regulation, already introduced in Chapter 1. The idea is to help reduce the need for defenses by reducing the anxiety that the warded-off affect brings up, and cognitive therapists will find much of this material familiar.

Building Motivation to Give Up the Affect Phobia

THERAPIST: What would be the hardest thing about setting a limit with some of these people?

PATIENT: I like being a nice person. It makes me uncomfortable to say no to people [anxiety that assertion will cause others to think ill of her].

THERAPIST: Saying no means that you're not a nice person?

PATIENT: I'm just generous by nature.

THERAPIST: That's wonderful. The world really needs generous people. But think of all the generous people you know. Do they always say yes when people ask them something?

PATIENT: Yeah, pretty much.

THERAPIST: Really? Even when they're already busy doing 10 other generous things at the same time, like you are? They always say yes when you ask them for something?

PATIENT: Well, maybe not always . . .

THERAPIST: OK, think of a time when one of these people said no to you. Did you think that they weren't nice?

Affect Experiencing: Desensitizing the Affect Phobia

The treatment objective of Affect Experiencing, covered in Chapter 7, is the heart of systematic desensitization: **Exposing** the patient to the physiological experience of the conflicted affect (while at the same time lowering the level of the associated anxiety) will heal the patient's conflict. Gestalt therapists are likely to feel at home with this material.

Exposure to Phobic Affect

THERAPIST: If you imagine your boss coming in with more work and expecting you to get it all done, how does it make you feel?

PATIENT: Like I'll never get it done [defends against anger with self-attack].

THERAPIST: So you would attack yourself again. But how would you feel **toward him**?

PATIENT: I don't know.

THERAPIST: Well, try to imagine the situation. What do you feel in your body?

PATIENT: I don't know, kind of an energy . . .

THERAPIST: What does your body want to do?

PATIENT: I . . . (*surprised*) it wants to hit him! That's terrible, isn't it? [Shame]

Regulating Anxiety during Exposure

THERAPIST: Well, if you **actually** hit him, that **would** be terrible—for both of you. We're never talking about actually hitting anyone; we're talking about freeing you up to have your feelings in your imagination. This way, you'll hurt no one, and it can help empower you to act more effectively. I will encourage you to experience your emotions in a safe place—here in this office—so that you can learn to understand them, bear them, and **always** control them. Later, this will help put your feelings in perspective and help you decide on the best course of action. But now let's go over that scary feeling once again, until you're feeling comfortable with the internal experience of anger [repeated exposure].

Affect Expression: Adaptive Expression of Feelings, Wants, and Needs in Relationships

Patients with Affect Phobias often will not have acquired skills for handling affect adaptively in interpersonal situations. After the conflict is reduced by repeated exposure, such skill acquisition is a relatively straightforward but terribly important part of the therapeutic work. The objective of Affect Expression, covered in Chapter 8, has a skill focus that many behavior therapists will find familiar.

PATIENT: Well, now I feel angry, but what good does it do? He's the boss, I can't do anything.

THERAPIST: Well, what are some ways you could use that new angry energy within you to make a firm but appropriate response to your boss and take better care of yourself?

Self-Image and Relationship with Others

Many of the conflicts that patients bring into therapy are accompanied by distorted views of themselves or others, and this is the focus of Chapters 9 and 10. This material will seem most familiar to those who focus on object relations. Work may focus on a balanced, compassionate view of the self and others:

PATIENT: But how can I ever find someone to love me if I'm just thinking about me, me, me all the time?

THERAPIST: Does saying no to people mean that you just think about "me, me, me"?

PATIENT: Yeah, it kind of feels that way. I mean, intellectually, I know it's not true, but that's how it seems to me.

THERAPIST: Of course, it's not doing someone else a favor to let yourself get overwhelmed by their desires. So where was it that you got that message that saying no meant you were selfish?

Therapy can also focus on a more integrated, balanced view of others:

PATIENT: He's been so good to me. I can't just say no to him.

THERAPIST: You've told me about a number of things that he's done that have been generous to you, it's true. But, actually, the behavior you've described around this—piling work onto you, and then pouting when you don't do the impossible—doesn't sound to me like he's being good to you.

PATIENT: Oh, he's a wonderful man.

THERAPIST: You know, he may be in many ways. But suppose your friend Beth told you that her boss was completely wonderful, even though he acted hurt when she didn't get five things all done at the same time?

PATIENT: Actually, a friend did tell me something like that—it wasn't Beth, it was someone else—and I got really mad. [Thus her perspective is changed, and she begins to see that it's all right to have angry feelings. She does not need to idealize her boss.]

As noted above, more impaired patients may need a heavy focus on this Self- and Other-Restructuring work, but small doses of it are important in many short-term therapies.

Part IV: Final Chapters

The book concludes with Part IV. Chapter 11 discusses how to apply this therapy in the context of specific DSM-IV diagnoses, and Chapter 12 covers termination.

Discussion of Main Terms

The full title of our companion volume, *Changing Character: Short-Term Anxiety-Regulating Psychotherapy for Restructuring Defenses, Affects, and Attachments* (McCullough Vaillant, 1997) contains a number of terms which appear repeatedly throughout this book. Below we discuss how each phrase in that title reflects an aspect of STDP.

Changing Character: . . .

Defenses, at their inception, generally represent a person's best attempt to cope. They may even have been adaptive, given the situation at that time. As years pass, however, defenses can generalize to situations in which they are increasingly less adaptive. At best, rigidly entrenched defenses block the fullness of experience; at worst, they lead to **character disorders**—longstanding maladaptive patterns of thoughts, feelings, and behavior.

Viewing psychodynamic conflict as Affect Phobia allows the application of the behavioral principles of learning theory to resolve psychodynamic con-

flict and therefore to **change character** or **personality** (i.e., to eliminate or greatly reduce these long-standing maladaptive patterns).

Short-Term . . .

This therapy has brought lasting helpful change in as little time as a single 3-hour evaluation for high-functioning, motivated patients who are ready for change. Other successful treatments have taken as many as 50 or more sessions. The goal is to be as time-efficient as possible, while allowing enough time for adaptive change. This necessitates a focus on specific treatment objectives related to the patient's core psychodynamic conflicts (Affect Phobias). The goal is not to complete all aspects of character change, but to start the process and put the tools of treatment into the patient's hands as soon as possible, so that change can continue in the ongoing context of the patient's life.

Fifty sessions or more is clearly not "short-term" as the managed care industry might define it. However, resolving many decades of character pathology in 12–18 months of therapy can certainly be considered time-efficient! The goal is to reduce the patient's suffering as much as possible as rapidly as possible. In addition to striving for lasting character change, this goal means that we must offer such change as rapidly as we can. There is often an economic benefit to the patient and society as a by-product; although this is important, it is a secondary consideration. This therapy is not offered as a "second-rate quick fix," but as a "first-rate, in-depth healing process." If it is also "quick"—in relative terms—we see that as enhancing its value to the patient.

Anxiety-Regulating . . .

Anxiety regulation is one of the fundamental techniques of this therapy. Patients' anxieties (or other maladaptive inhibitory affects) are repeatedly elicited, explored, and reduced in the process of systematic desensitization of Affect Phobia. This is in contrast to **anxiety-provoking** therapies (analogous to the behavior therapy technique of flooding). Although these therapies are effective for patients who can tolerate a high level of anxiety provocation, we believe that anxiety regulation can bring these benefits to a much broader group of patients.

Psychotherapy . . .

This therapy is fundamentally psychodynamic, but it differs from classical psychoanalysis and some traditional long-term psychodynamic psychotherapy in important ways. One fundamental difference is that the therapist is not "neutral," but actively engaged:

- **The therapist maintains a goal-directed treatment focus.** Otherwise, the therapist might collude with the patient's defenses in avoiding conflicted affect and avoiding change.
- **The treatment style is active and collaborative.** Interpretations are generated almost immediately and developed in an active therapeutic collaboration between patient and therapist.

- **The treatment can be directive.** The therapist is willing to teach or guide the patient when appropriate.
- **A full transference neurosis is not allowed to develop.** Transference issues are generally identified immediately, so that they can be worked through as they arise.

for Restructuring . . .

Restructuring can be thought of as reorganizing the way people view, experience, and remember the world. It is achieved primarily through the process of systematic desensitization, but the treatment objectives outlined above help the therapist focus on several aspects of restructuring. In this process, defenses become more flexible, affects are freed up, anxieties are reduced to adaptive levels, and self-image and attachments to others are altered.

Defenses, Affects, . . .

The overarching goal is the resolution of the psychodynamic conflicts underlying the patient's difficulties by systematic desensitization of their Affect Phobias. To do this, the patient first needs to give up defenses—the behaviors used to avoid conflicted adaptive affects. When the defenses are less firmly entrenched, the patient is better able to experience the adaptive affects with a reduced level of anxiety.

and Attachment

Healthy attachment means having a balance between autonomy and interdependence, with relationships that are intimate and authentic, and that also allow for healthy (rather than need-based) dependence. In addition, attachment to others is intimately intertwined with what can be thought of as "attachment to self." We all need affirmation from others throughout our lives. But we also need to do what healthy early attachment enables people to do: hold onto and contain in our memories a "reservoir" of the love and support of others, so that we are not quickly depleted when others are absent or less affirming than we would like. Although transference distortions are readily pointed out, this therapy emphasizes the real relationship between patient and therapist to help build a new capacity for healthy attachment.

Conclusion

Our intention in this book is to offer a coherent "package" of STDP theory and technique—one that leads to effective, time-efficient therapy. Of course, every therapist assimilates new information and techniques through and then into his or her individual style. We recognize that aspects of this therapy may not be to everyone's taste, and if that's the case for you, we invite you to "take what you like and leave the rest." In any case, our hope is that the point of view and techniques in this book will help you as they have helped us: to do more effective and time-efficient therapy for our patients.