A qualitative exploration of affect organization in patients with social anxiety disorder

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ABSTRACT

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Background: This study explored affect organisation in patients diagnosed with social anxiety disorder (SAD) using qualitative methodology. Building on the affect consciousness model, participants were asked about aspects of affect integration in nine discrete or basic affects. The nine discrete affects were interest/excitement, enjoyment/joy, fear/panic, anger/rage, shame/humiliation, sadness/despair, envy/jealousy, guilt/remorse, and tenderness/care. The aspects of affect integration were scenes, awareness, tolerance, non-verbal expression, and conceptual expression. The primary affective problem (i.e. the nuclear script) was sought identified for each participant, and patterns of maladaptive affect organisation across the participants were searched for. This study expands on previous research investigating emotion regulation in individuals with SAD.

Methods: The data material used in this study was obtained from the Norwegian Multisite Study on the Process and Outcome of Psychotherapy. Seven outpatients diagnosed with SAD were interviewed with the Affect Consciousness Interview (ACI) before the start of psychotherapy. The interviews were transcribed and were subject to thematic analysis: First, the primary affective problem for each participant was established on the basis of the ACI using a predefined procedure for nuclear script identification. Second, based on the preceding within-case analysis, patterns of maladaptive affect organisation across the participants were searched for.

Results: Five major themes were identified in the analysis. First, all participants appeared to experience overwhelming or near-overwhelming shame and fear in social situations. Second, the majority of the participants seemed to experience generalized and overwhelming feelings of guilt. Third, there appeared to be a disturbance in self-assertiveness across the participants, as witnessed in anger and interest. Fourth, the communication of vulnerability and tenderness seemed to be disturbed across the participants. And finally, the majority of the participants appeared to experience paralyzing sadness because of perceptions of social deficits in themselves and social rejection.

Conclusion: Several significant patterns of maladaptive affect organisation were found across the group of patients diagnosed with SAD. These patterns of maladaptive affect organisation concern both discrete affects (e.g., sadness, anger, and shame) and aspects of affect integration (e.g., awareness and conceptual expression). Several of the patterns correspond to previously known characteristics of people with SAD. Although preliminary, these findings seem to be promising, and to suggest that more research should be directed towards exploring the role of discrete affects and aspects of affect integration in SAD and other psychopathological conditions.

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INTRODUCTION

Today research into the role of affect and emotion in the anxiety disorders, and psychopathology in general, is steadily increasing. However, it was not until the early 2000s that research into affect- and emotion-related aspects of social anxiety disorder (SAD) gained momentum (Farach & Mennin, 2007). Before this, theorizing and research into the nature of pathological social anxiety was almost solely conducted from a cognitive perspective, with perhaps the most influential model being formulated by Clark and Wells (1995).

It is becoming clear that the role of affect and emotion in psychopathology and the anxiety disorders is of central importance and warrants a strong research effort (Barlow, 2002). Early research on affect and emotion in SAD explored topics such as affective consequences following social interaction, nonverbal behaviour associated with the disorder, and emotion-related cognitive processes (Kring, 1999). In the context of affect- and emotion-related research on SAD, it has been the study of emotion regulatory processes that has received the most attention in recent years. Mennin (2005) developed a model of emotion dysregulation for the anxiety and mood disorders based on a general model of emotion regulation as formulated by Gross (1998). In this model, emotion disruption and dysregulation may be reflected in (1) heightened intensity of emotions; (2) poor understanding of emotions; (3) negative reactivity to one's emotional state (e.g., fear of emotion); and (4) maladaptive emotional management responses. Based on the empirical application of this model, Mennin and other researchers have recently discovered several characteristics of emotional dysregulation in people with SAD. Turk, Heimberg, Luterek, Mennin, and Orsillo (2005) found that relative to a non-anxious control group people with SAD were less expressive about positive emotions, had greater difficulties identifying the emotions they are experiencing, had more difficulties describing the emotions they are experiencing, and are less aware of their emotions. They also found that people with SAD exhibited negative reactivity to several emotions, reporting more fear of anxiety, anger, depression, and positive emotions than a non-anxious control group. And lastly, they found that people with SAD had greater difficulties repairing a negative mood than non-anxious controls, indicating maladaptive emotional management. The Turk et al. (2005) study relied on self report among a college student population to identify people with SAD and used measures of emotion regulation that were not designed to denote dysfunction. In a follow-up study Mennin,

McLaughlin and Flanagan (2009) studied emotion regulation using a structured clinical interview to ascertain diagnoses, as well as using self report measures of emotion regulation that had previously been used in clinical populations. This study replicated the original finding of Turk et al. (2005) that people with SAD had poorer access to effective emotional management strategies than controls. Also, the previous finding that SAD participants exhibited poorer understanding of emotions than controls was replicated. However, in this study people with SAD reported experiencing greater intensity of emotions than controls, contradicting the finding of no differences in the Turk et al. (2005) study. Some aspects of emotional dysregulation that were examined in the first study were not tested in the later one, because the measures used between the studies had somewhat different content. So for instance, the original finding that SAD participants were less expressive about positive emotions could not be replicated.

Turk et al. (2005) and Mennin et al. (2009) simultaneously studied emotional dysregulation in people with generalized anxiety disorder (GAD). GAD is a highly co-morbid disorder with SAD, and the investigators in these two studies wanted to test if their model of emotional dysregulation could differentiate between these anxiety disorders. They did find some differentiating aspects of their model on GAD and SAD, but also several aspects that did not differentiate between them. The most robust differentiating finding was that GAD participants reported experiencing emotions with higher intensity than SAD participants. Also, in both studies SAD participants reported having poorer emotional understanding than GAD participants. A central non-differentiating finding in both studies was that GAD and SAD had equal levels of difficulties in accessing effective emotion regulation strategies.

A few studies have explored relations between specific affects and SAD. Thus, Hyde (2003) found shame (as measured by the Internalized Shame Scale) to have a unique role in social anxiety relative to generalized anxiety. That is, he found a strong correlation between shame and measures of social anxiety, and this correlation was significantly higher than the correlation between a measure of generalized anxiety and shame. Moscovitch, McCabe, Antony, Rocca, and Swinson (2008) found that despite reporting a greater propensity to experience anger than non-anxious controls, patients with SAD reported significantly lower levels of verbal aggression than controls. This replicated a study by Erwin, Heimberg, Schneier, and Liebowitz (2003) who similarly found that persons with SAD exhibited greater anger but poorer anger expression skills than a non-anxious control group.

Some studies have explored relations between positive affect, negative affect and SAD. An affective profile of low positive affect combined with high negative affect

previously considered specific to depression, also appears to characterise SAD (Brown, Chorpita, & Barlow, 1998; Kashdan, 2002, 2004).

A relatively large number of studies have been published exploring certain emotion-related cognitive phenomena in relation to SAD. This is not surprising considering the predominance of cognitively oriented theories on the nature and treatment of SAD (e.g., Clark and Wells, 1995). The emotion-related cognitive phenomena studied mostly concern various biases in attending to negative emotional stimuli, e.g. angry faces and threat words (e.g., Garner, Baldwin, Bradley, & Mogg, 2009; Langner, Becker, & Rinck, 2009), and their biological correlates (e.g., Sewell, Palermo, Atkinson, & McArthur, 2008).

However, there has been no study to date that explores SAD from a basic affects or differential emotion perspective, systematically analyzing functioning on a variety of basic affects and the dynamics within and between them. Until now the research effort has mainly been directed towards exploring global constructs such as negative versus positive affect and emotion regulation, and various emotion-related cognitive constructs in relation to SAD (Farach & Mennin, 2007; Kring, 2001). The field is also characterised by a restricted range of methodologies. Most of the studies reviewed above rely on self-report measures of various scales reflecting the constructs being studied. As called for by Kring (2001) and Kring and Bachorowski (1999) when reviewing the status of emotion-oriented research in psychopathology one decade ago, there is a need for more diverse methodologies from different theoretical perspectives on emotion. The present study is based on the affect consciousness model developed by Monsen and colleagues (Monsen, Ødegård, & Melgård, 1989; Monsen, Eilertsen, Melgård, & Ødegård, 1996; Monsen, Odland, Faugli, Daae, & Eilertsen, 1995a, 1995b; Solbakken, Sandvik-Hansen, & Monsen, 2010a). The affect consciousness construct is based upon an integration of several theoretical perspectives on affect and emotion, most notably Tomkins' affect- and script theory (Tomkins, 1995a, 1995b, 1995c; 2008a, 2008b) and differential emotions theory (Izard, 1977; 1991; 2007; 2009). Modern self-psychological formulations as those advocated by Stolorow, Brandschaft, and Atwood (1995), Stolorow and Atwood (1992), and Basch (1983), are also central, as well as the writings of Stern (1985) and Emde (e.g., Sorce, Emde, Campos, & Klinnert, 1985). Affect consciousness refers to the mutual relationship between activation of basic affective experiences and the individual's capacity to consciously perceive, tolerate, reflect upon and express these experiences. This capacity for awareness, tolerance, reflection and expression of affect is seen as necessary for the integration of affect in cognition, motivation and behaviour (Solbakken et al., 2010a). Affect is considered a basic motivational system of vital importance

for normal psychological functioning as well as being centrally implicated in psychopathological functioning. The affective system is seen as shaped by evolution and inherently adaptive for the individual. Human beings are thus equipped with a set of universal, basic and unlearned affects, present at birth or shortly thereafter. The affect consciousness construct represents an expansion of Basch's (1983) conceptualisation of the relation between affect, feeling and emotion. Basch defines affect as unlearned, somatic reactions that are separate from cognition. Feeling, on the other hand, is defined as the awareness of these basic affects, an awareness that typically appears in the developing child around 18-36 months. And emotion refers to more complex organised states that include cognitive appraisals, action-tendencies and somatic reaction patterns. In agreement with Tomkins (e.g., 1995c), any organisation of affect is termed script in the affect consciousness model. We do not agree with Basch on his reductionist view on the nature of affect as "somatic reactions", but his framework is nevertheless somewhat clarifying. There is presently not full agreement between theorists on precisely what affects can be considered basic, but the affect consciousness model follows largely Tomkins (2008a; 2008b) and Izard (1991) and includes 11 affects. These affects are interest/excitement, enjoyment/joy, tenderness/care, fear/panic, anger/rage, shame/humiliation, disgust, contempt, sadness/despair, envy/jealousy, and guilt/remorse. These affects are seen as organised as scripts in the individual. The script-concept is similar to the cognitive schema-concept, and refers here to implicit rules for understanding, predicting, controlling, producing, and handling affective and emotional experiences. It can be viewed as a higher order organisation of affect and cognition. Although cognition is considered being centrally involved in scripts, cognition is not viewed as having primacy over affect. Cognition and affect is viewed as separate but highly interconnected systems, in line with several influential theoretical formulations (e.g., Damasio, 1999; Ekman, 2003; Izard, 2007, 2009; Panksepp, 2007; Tomkins, 2008a, 2008b). This contrasts with cognitive-constructive theories that see the experience of specific emotions as the result of appraisal processes upon undifferentiated "core affect" (e.g., Barrett, 2006). Through development an individual creates a large number of scripts in dealing with his or her diverse affective and emotional experiences, essentially reflecting important aspects of the individual's personality. However, in various circumstances maladaptive scripts can be developed, contributing to self-defeating behaviour and psychopathology (Monsen & Monsen, 1999). Such maladaptive scripts have been termed nuclear scripts by Tomkins (1995a). The affect consciousness construct has been operationalised as degrees of awareness, tolerance, nonverbal expression, and verbal

expression of 11 discrete affects (Monsen, Monsen, Solbakken, & Hansen, 2008). A semi-structured interview (ACI) and separate scales (ACS) have been developed to assess these four aspects of affect consciousness and integration quantitatively (see Monsen et al. (1996) for its psychometric properties). This interview also provides rich qualitative information on the dynamics of scripts in and between the 11 discrete affects being explored. We have adopted this interview to study the role of discrete affects and their scripts in patients with SAD.

Although we have found no studies in the literature exploring SAD from a basic affects or differential emotion perspective, Fox (2009) studied the role of basic emotions in anorexia nervosa using a grounded theory methodology. Since this is the only study we have found in the psychopathology literature resembling our approach, it warrants closer examination. Fox interviewed 11 patients with anorexia nervosa at a regional eating disorder unit in Great Britain. He developed a semi-structured interview asking questions about various emotion-related issues, including what participants understand by emotions, when they experience different emotions and how they express these emotions. His theoretical perspective on basic emotions was informed by Power and Dalgleish's (2008) cognitive theory of basic emotions. This theory asserts that five basic emotions can be identified based on certain appraisal scenarios being universal across cultures. These basic emotions are fear, sadness, anger, disgust and happiness. Fox adopted the methodological principles of open coding and theoretical sampling, analysing interviews alongside data collection and gradually developing a theory of the phenomenon under study. This is a highly inductive analytical approach, resulting for instance in some questions being changed, added or dropped as theoretical insights emerge. Two over-arching themes were identified in the analysis. The first theme concerned the development of poor meta-emotional skills in childhood. This theme consisted of two subthemes, namely the experience of overwhelming affect in the family (e.g. witnessing violent anger) and poverty of emotional environment (e.g. the active suppression of emotion by family members). The second over-arching theme concerned the present perception and management of emotion and consisted of several sub-themes, including the inhibition of emotion (especially anger and sadness), lack of clarity with emotions, and the unacceptability of self to express emotions.

There are important similarities and differences between our study and that of Fox (2009) regarding both theory and methodology. Theoretically, both our study and Fox (2009) were concerned about the role of basic affects or emotions. But the studies differed in their views on the relation between affect and cognition, with Fox referring to an emotion theory

(Power & Dalgleish, 2008) which sees the experience of emotion as fundamentally the result of controlled or automatic (learned) cognitive appraisals. The concept of basic affects has no place in this theory (although they allow for hardwired and unlearned fear responses to certain stimuli). In our view, emotions arise from the interaction of the separate but highly interconnected systems of affect and cognition. Another theoretical difference is that we have adopted an elaborate model of affect integration into our study, while Fox did not assume a priori different functional aspects of basic emotions (e.g., awareness, tolerance, and expression). Thus, our present study was more theoretically driven than that of Fox (2009). Methodologically, both studies explored the experience and organisation of basic affects and emotions using qualitative methods. Fox (2009) adopted a version of grounded theory and essentially performed a form of thematic analysis of his data. As already mentioned, our approach was more theoretically driven and the use of an inductive methodology like grounded theory would not be appropriate. However, like Fox (2009) we performed a version of thematic analysis in the present study, but one that is more a priori theoretically founded (see Braun & Clarke (2006) for an elaboration of different forms of thematic analysis used in psychological research).

As discussed above there is a paucity of research into the role of basic affects or differential emotions in SAD. The research paradigm that has come closest is the study of emotional dysregulation in SAD by Mennin and colleagues (e.g., Mennin et al., 2009). At the same time several investigators (e.g., Monsen & Monsen, 1999; Power & Dalgleish, 2008; Solbakken et al., 2010a) suggest that basic affects or differential emotions might play a significant role in psychopathology. Therefore we wanted to study how basic affects are organised through scripts in patients with SAD with the following questions in mind:

- Are there certain basic affects that seem to be especially problematic for these patients?
- And if so, in what way are they problematic for the patients? To answer this latter question, we specifically explored four different aspects of affect integration (as described above) that might be problematic: awareness of affect, tolerance of affect, non-verbal expression of affect and verbal expression of affect.

A qualitative inquiry was considered appropriate for particularly two reasons. First, qualitative methods can generate rich and complex data that can be subject to nuanced analysis, producing rounded and contextual understandings (Mason, 2002). The field of

affects and affect organisation is inherently complex and may benefit from more “holistic” methodological approaches. Second, there has been no research so far exploring the issue of affect organisation in SAD. Therefore, there are few leading threads into what specific affects or aspects of affect integration that might be especially problematic for this patient group. And so, a qualitative inquiry and analysis might provide fertile ground for further investigation using other methods, including correlational and experimental research.

METHODS

Overall methodological strategy

A version of thematic analysis was conducted in this study. Thematic analysis can be defined as a "method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Wilkinson, 2006: 79), and can accommodate a variety of epistemological and analytical positions. Many forms of qualitative research can be classified as thematic analysis, although they might be labeled otherwise. Referring to the framework of thematic analysis as explicated by Braun and Wilkinson (2006), the present study had several characteristics. First, we were conducting a theoretical thematic analysis. Several aspects of our inquiry were theoretically predetermined, as exploring differential affects and aspects of affect consciousness within them. However, within the specific affects and aspects of affect consciousness, we tried to be without expectations as far as possible and let the data "speak to us". We also had no specific expectations regarding patterns of affect organization in the group of patients with social anxiety disorder (SAD). So in that way, our enquiry was both theoretical and inductive. Second, we tried to give a quite rich account of the entire data set, rather than a detailed account of one aspect of it, although we were concerned about maladaptive affect organization, and not affect organization at large. Third, we were concerned both about semantic and latent themes. Although we listened sensitively and were very interested in the subjective accounts of the participants, we interpreted these accounts in light of the affect consciousness model.

The present study strived to adhere to the general principles of sound qualitative research as explicated by Elliot, Fischer, and Rennie (1999). In addition to specifying principles of good research practice common to qualitative and quantitative research, they listed principles especially pertinent to qualitative research, including situating the sample, grounding in examples, providing credibility checks, coherence, and resonating with readers.

Participants and procedures

The data material for this study originated from the Norwegian Multisite Study on the Process and Outcome in Psychotherapy. Ethical approval had been granted from the Regional Ethical Committee for health research before data collection started. Participation was based on informed and signed consent. Altogether 166 outpatients at several district psychiatric units within the Norwegian Public Health system were interviewed with the Affect Consciousness Interview (ACI) at the start of therapy. Diagnosis and co-morbidity were assessed according

to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994) through the Structured Clinical Interviews for DSM-IV for Axis I and II (SCID I & II; First, Spitzer, Gibbon, Williams, & Benjamin, 1994). Other interviews and tests were also administered that were not relevant to this study. The interviewers were trained clinical psychologists and psychiatrists. Altogether 50 of the participants were diagnosed with social anxiety disorder (SAD). Of these participants only 2 had no co-morbid symptom- or personality disorder. The selection of participants among the 50 diagnosed with SAD was based on two criteria. First, we strived for a selection of participants without co-morbidity in other classes of psychopathology than the anxiety disorders. This was meant to reduce some complexity in interpretation and analysis. However, since more than half of the 50 participants with SAD had co-morbid avoidant personality disorder, the presence of this particular personality disorder was not used as an exclusion criterion. Actually, whether avoidant personality disorder and SAD are distinct disorders is an open issue in the literature (e.g., Reich, 2000; Widiger, 2003; Reichborn-Kjennerud et al., 2007). Second, because this was one of several parallel studies on affect organization and psychopathology, co-morbidity with diagnoses focused on in these other studies was avoided. This was meant to strengthen the comparative potential between the studies. Since one other study examined affect organization in generalized anxiety disorder, the presence of this co-morbid anxiety disorder was used as an exclusion criterion. With the application of these two selection criteria 7 participants were included in the study, four females and three males aged 20-54 years. Co-morbidity and demographic data for the participants are presented in table 1. The participants have been anonymized by removing information that could identify them. The names used in this study have been selected arbitrarily.

Table 1

Demographic and co-morbidity data for the participants

	Demographic characteristics		Comorbidity with social anxiety disorder			
Participants	Age	Gender	APD	PanD	AgF	SpF
Nikolai	33	M				
Kjell	41	M				
Janne	50	F	X			
Gunn	54	F	X			
Trine	26	F	X	X		
Hans	20	M	X		X	
Sunniva	36	F	X	X		X

Note. X = presence of co-morbid disorder; APD = avoidant personality disorder; PanD = panic disorder; AgF = agora phobia; SpF = specific phobia.

The Affect Consciousness Interview (ACI)

The Affect Consciousness Interview (ACI) was developed by Monsen and colleagues to explore and measure aspects of affect consciousness (AC) as part of the Tøyen project of intensive psychotherapy for patients with personality disorders (Monsen et al., 1989).

AC is defined as the mutual relationship between activation of basic affective experiences and the individual's capacity to consciously perceive, tolerate, reflect upon and express these experiences (Monsen & Monsen, 1999). The construct has been operationalised as degrees of awareness, tolerance, non-verbal expression, and conceptual expression for each of, in the most recent version of the model, 11 basic affects. Separate scales have been developed to assess these aspects of AC quantitatively (Monsen et al., 1996). The construct validity and external validity of AC was recently assessed in a clinical sample (Solbakken, Hansen, Havik, & Monsen, 2010b). Reliability was measured in terms of inter-rater reliability and generalizability estimates, and was shown to be good. A factor structure was identified where discrete affect categories, as measured across the four affect integrating aspects, were identified as factors. Previously, several studies have indicated the theoretical and clinical usefulness of the AC construct (e.g., Choi-Kain & Gunderson, 2008; Lech, Andersson, & Holmqvist, 2008; Monsen & Monsen, 1999; Monsen et al., 1989; Waller & Scheidt, 2004).

Nine basic affects were included in the version of the model used when collecting the data for the current study. These affects were interest/excitement, enjoyment/joy, fear/panic, anger/rage, shame/humiliation, sadness/despair, envy/jealousy, guilt/remorse and

tenderness/care (disgust and contempt have been added to the current version of the model). In the ACI questions are asked about each of the aspects of AC. The specific questions being asked are presented in table 2.

Table 2

Questions asked in the Affect Consciousness Interview

TELL ME ABOUT SOMETHING THAT MAKES YOU FEEL (Q 1-6):	or	WHAT MAKES YOU FEEL (Q 7-11)
1) INTERESTED OR EXCITED		7) SHY, HUMILIATED OR ASHAMED
2) ENJOYMENT OR JOY		8) SADNESS OR DESPAIR
3) FEAR OR PANIC		9) ENVIOUS OR JEALOUS
4) ANGER OR RAGE		10) GUILT OR REMORSE
5) CONTEMPT		11) TENDERNESS, CLOSENESS OR DEVOTION
6) DISGUST OR REVULSION		

After each initial question addressing associated scenes, the following points need to be explored:

1. **Awareness:**
   How does the participant feel, sense, become aware of, recognise or notice that he or she becomes interested, joyful, etc. (Affect 1-Affect 11, the specific affect category).
   Check for bodily and mental criteria.

2. **Tolerance:**
   a) Impact: How and to what extent, does the affect typically impact upon the participant?
   b) Coping (with impact): Does the participant allow himself or herself to be moved by the affect? To what degree can the person bear the feeling, carry or contain the psychomotor movements and the mood content inherent in the affect?
   c) Signal function: Does the participant try to decode the signal value or reflect on the mood content as a means of attaining personal and interpersonal knowledge? Is there a capacity for using affects and the specific feeling qualities as self-signals and as conveyers of meaningful information?

3. **Nonverbal expression:**
   referring to
   a) Avowal: i.e., if the participant is capable of showing affect expressions in an avowed manner
   b) Typical display of expressions via bodily posture, tone and pitch of voice, facial expressions and so on. How, typically, does the participant show the affect or express himself or herself non-verbally in different kinds of object relationships; e.g. with significant others, persons they do not know very well, or when they are alone?

4. **Conceptual expression (Verbal):**
   referring to
   a) Avowal i.e. if the participant is capable of articulating affect experience in an avowed manner
   b) Typical articulation of affect experience. How does the participant most typically tell others, or articulate his or her affect experiences in different interpersonal settings?

Note. The affects contempt and disgust/revulsion were not included in the present study. Adapted from "The Affect Consciousness Interview (ACI) and the Affect Consciousness Scales (ACS): Instructions for the interview and rating," by J. T. Monsen, K. Monsen, O. A. Solbakken, and R. S. Hansen, 2008, *Unpublished manuscript*, p. 2.

Analysis

The video-taped interviews were transcribed by hired secretaries who were instructed to produce a verbatim record of them, but not including non-verbal expressions like sighs and pauses. The accuracy of the transcriptions was checked by the researcher through listening to the tapes, and a few changes were made to the original transcriptions.

The analysis of the interviews was divided into two phases: a within-case analysis and an across-case analysis (see Mason (2002), and Miles and Huberman (1994) for an explanation of the logic of within-case versus across-case analysis in qualitative research). First a within-case nuclear script analysis was conducted where the objective was to identify the primary affective problem for each participant based on the ACI. Then an across-case thematic analysis was conducted to search for common patterns and variations across the participants, based on the preceding nuclear script analysis. The steps in the analysis will be described below.

Nuclear script analysis

The nuclear script analysis can be divided into two main parts. In the first part, each of the 9 affects was analyzed separately for significant script dynamics. In the second part, the analysis shifted to the search for significant patterns indicating pathological functioning and the operation of a nuclear script *across* the 9 affects in the individual.

In the affect-for-affect analysis each interview was thoroughly read through several times. Summaries of the main thematic content for each of the 9 affects were written. Simultaneously, a script schema was created for each affect, where scripts extracted from the interview were pasted into it. In this context, a script refers to an abbreviated statement extracted from the ACI, that indicates something about the participant's affect organization and affect consciousness. The script schema consists of columns corresponding to the aspects of the AC construct: scenes, awareness, tolerance, non-verbal expression, and conceptual expression. In the script schema, significant dynamics within and between extracted scripts indicating pathological functioning are also noted using certain signs. The dynamics thus noted include conflict (e.g., by the suppression of affect), being overwhelmed by affect, couplings to other affects, the rupture of affect experience (e.g., by the replacement of one affect by another), and affect fusion (i.e., two or more affects are indistinguishable from each other on an aspect of affect consciousness). The main justification for this visual representation of scripts in schemas is that it eases the search for significant patterns

indicating pathological functioning, and thus helps in identifying each participant's nuclear script (i.e., primary affective problem). It also eases the later across-case search for patterns of maladaptive affect organization. Each affect was also scored on the aspects of AC using specified scoring criteria (see Monsen et al., 2008). A low score (below 5 on a scale from 1-9) indicates conflict or pathological functioning on that aspect. The ACI consists of 36 scores (9 affects multiplied by 4 aspects of affect consciousness). These scores were used as an indication of where to look for nuclear script content within the individual in the second part of the nuclear script analysis: Scores were computed and specific affects or specific aspects of AC with low average scores were given particular attention. In Appendix I an example of a script schema is given for the specific affect of one participant with its attendant scores.

In the second part of the analysis, the nuclear script of each participant was identified based on the preceding affect-for-affect analysis. Using the summaries for each affect and the script schemas, as well as the scores indicating low affect integration, significant patterns indicating psychopathological functioning were identified. Scenes, affects and script patterns appearing to reflect the most pressing and unsolvable problems for the individual were thus selected. This material was then pasted into a nuclear script schema. In the nuclear script schema the primary affective problem of the individual, as evaluated on the basis of the ACI, is represented. In Appendix II the nuclear script schemas for the 7 participants are presented. A more detailed presentation of the procedure of identifying nuclear scripts based on the ACI can be found in Monsen and Monsen (n.d.). Although subjective interpretation on behalf of the researcher certainly impacts the nuclear script analysis, adherence to the nuclear script identification procedure as described above should produce relatively consistent results. Ideally, if following the recommendations of Boyatzis (1998), the nuclear scripts should have been created independently by two researchers to evaluate reliability. This was not possible due to the time-consuming nature of this form of analysis and practical constraints in the present study. Such a check on the reliability of thematic analysis is also not generally recommended in qualitative research (Braun & Clarke, 2006). The emphasis is rather on constructing valid arguments based on rigorous and verifiable analytical procedures (Mason, 2002). However, several of the nuclear scripts used in this study have been validated in group meetings with fellow graduate students and the supervisor in the project group.

Across-case analysis

After completing the within-case nuclear script analyses described above, a search for patterns in affect organization across the participants started. The primary goal in this phase of the analysis was to identify significant affective problems that seemed to be shared by the participants. However, also variations in significant affective problems were looked for.

Specific affects being present in several of the nuclear scripts were given special attention. The presence of a specific affect across the nuclear scripts of the participants suggests it is central in understanding common processes and mechanisms in pathological functioning. When such an affect was identified, a detailed analysis of this affect across the participants followed. In that analysis several aspects of the data material were utilized. First, the single affect script schemas created in the first part of the nuclear script analysis were consulted again. Second, the summaries written simultaneously with these affect script schemas were re-read. Third, the interviews themselves were re-read for the specific affect analyzed. Following this procedure, commonalities and variations in different aspects of organization in the specific affect across the group were identified. For instance, it would be interesting to identify similarities in thematic content across the participants on the scenic aspect of an affect. This analytical process was repeated for each affect that was present in the majority of the seven nuclear scripts. During this analysis patterns of relations *between* affects were also noted. For instance, if two or more specific affects are coupled into each other in several of the nuclear scripts, this might signify an important commonality in affect organization. One way for the reader to evaluate the validity of the present analysis is by studying the nuclear scripts presented in Appendix B.

Extracts in the interviews that appeared to illustrate central themes or important aspects of these themes were selected for the Results. The language spoken in the interviews was Norwegian. When extracts were identified for use in the Results, they were translated to English using a large Norwegian-English dictionary (Kirkeby, 2003). Translations were sought to follow the original wording as close as possible, but at the same time adhere to the grammatical structure of English. When Norwegian idioms were used that were not directly translatable to English, they were translated using a Norwegian-English dictionary of idioms (Follestad, 1989).

RESULTS

Overview

We have identified five central themes in the analysis of nuclear scripts across the group of seven patients diagnosed with social anxiety disorder (SAD). These themes are: (1) activation of overwhelming shame and fear in social situations; (2) overwhelming and generalized feelings of guilt; (3) a disturbance of self-assertiveness; (4) a disturbance in the communication of vulnerability and tenderness; and (5) paralyzing sadness.

Social situations activate overwhelming shame and fear

Our analysis of this theme is clustered around three sub-themes: (1) experience of overwhelming shame in social situations; (2) a lack of differentiation in the experience of shame and fear; and (3) experience of overwhelming fear in social situations.

Experience of overwhelming shame in social situations

In all seven participants overwhelming or near-overwhelming shame seems to be activated when encountering social situations of significance. Additionally, in some participants a sense of shame seems to be almost ever-present. When asked about when he experiences shame, Hans describes a fundamental and ever-present sense of shame on the one hand and a more specific shyness in social encounters on the other:

> P: For everything that exists, I feel shameful for that. So that one is kind of ok.
> T: That's quite a lot.
> P: Yes… if I were to specify things, then it will be things like going out talking with people, then you get shy. I suppose you don't get shameful then, but at least you get shy.
> T: Yes. You distinguish somewhat between being shy and being shameful?
> P: Yes. Shameful, I guess that's mostly something I am towards myself all the time.
>
> (Hans)

When asked how he is aware of this experience of shame he describes it as "I guess you feel bad and degrading, you feel insignificant. Feel kind of less significant." And the impact of shame is likely overwhelming for Hans as it "makes me keep away as much as possible from people. Hide as much as possible." He is apparently stuck in feelings of shame as he notes that: "That one is more difficult to get rid of, really, because I feel like this all the time. You never get completely rid of that one, but I don't do anything specifically about it." He also states that: "If I'm shameful about myself, it ends up in getting depressed."

Janne also describes a pervasive sense of shame in addition to more specific shyness:

> P: In many situations I feel inferior (...) Then I get shy and shameful. (…) I struggle with writing- and reading difficulties, those situations are hard.
> T: Hm. Then you feel that you can be both shy and maybe shameful.
> P: Yes. I think it's embarrassing.
> T: Yes. Are there other circumstances where you feel...
> P: Yes. I've always felt I've been too fat, so that I'm shy about, my body.
> T: Hm.
> P: And I'm a little shy toward strangers (...) I'm not a world citizen, who kind of…
>
> (Janne)

Janne describes her awareness of shame as a "desire to withdraw and become invisible." She is also aware of vague bodily signals: "It's not good (…) it's painful (...) Kind of a lump inside of me." The impact of shame is likely rather overwhelming as she wants to put her hands around herself when these feelings arise. She describes herself becoming silent and closed. She is not certain of how she deals with shame, but when asked by the interviewer if she tries to rid herself of the feeling she confirms this.

Nikolai describes a variety of situations in which he becomes shy, including presentations, meeting women, raising his hand in lectures and meeting strangers. He becomes shameful if he has been doing or saying anything silly or rude while out drinking with friends. He is aware of several bodily signals when he becomes shy or shameful: he blushes, gets butterflies in his stomach and heat cruises. He also feels "a little afraid and uncertain, or what to call it." The impact of shame in Nikolai is probably quite overwhelming:

He becomes silent and withdraws from the situation. He also gets angry if someone comments on his apparent shyness, which also makes him even more shameful. Often he tries unsuccessfully to overcome the feelings of shame: “Push down, kind of get it under control (…) I try to get rid of it, but it really gets out of hand for me.” He thinks that shyness and shame inhibit his functioning to a great extent. He talks about a tendency to self-reproach because he has problems accepting this inhibition: “I try to overcome it by saying that I don’t need to have so much feelings of shamefulness (…) Instead of enjoying what I do it rather becomes the self-reproach.”

Only Hans and Gunn state explicitly that they experience a more or less ever-present sense of shame. However, it seems evident in other parts of the interview that feelings of being of less worth than others is a general characteristic of the participants that arise in most social interactions. Since social interaction is very difficult to avoid in daily life for most people, these feelings of inferiority and being of less worth are bound to arise frequently, perhaps so often that they will be experienced to be more or less ever-present in most of the participants, in a similar way as that explicitly indicated by Hans and Gunn. More data on how these feelings of inferiority impact different kinds of social interaction among the participants are presented in later sections in the results.

A lack of differentiation in the experience of fear and shame: fusion and couplings

In most of the participants, the experience of shame and fear appears to be undifferentiated to a greater or lesser extent. In three of the participants fear and shame are indistinguishable from each other with regard to the scenes where these two affects are activated. Nikolai exemplifies the fusion of shame and fear on the scenic aspect: Recall that Nikolai described himself as shy and shameful in a variety of social situations. In fear he lists analogue scenes, namely meeting women and holding presentations. He also mentions other shame-related scenes like fear of losing contact with friends and a fear of what others might think of him if he says too much about himself. In fact, all the fear scenes Nikolai describes are shame-related. However, Nikolai differentiates between fear and shame when it comes to awareness of the two affects, as well as the tolerance (impact and coping) of them.

In Gunn, fear and shame additionally seem to be fused on the awareness and tolerance aspects of the affects. The signals making Gunn aware that she is experiencing fear are “a stomachache” and “wanting to run away,” while in shame the only awareness signal she describes is “being embarrassed.” The first fear signal, a stomachache, is a diffuse bodily

signal which could be present in a variety of affective states. The second fear signal, wanting to run away, can be considered a common signal for fear and shame. Being embarrassed is a signal which she uniquely ascribes awareness of shame. So we see here that although her awareness of shame is "pure", her awareness of fear seems to be rather indistinguishable from her experience of shame. Shame and fear also seems to be fused on the tolerance aspect: Gunn describes the impact of fear as "very bad". She says: "Then it gets more reserved and withdraws (...) don't want to have contact at all." And describing how she copes with fear, she says: "I don't think I do that much about it either. It's just there until it disappears." This comes quite close to her description of the impact and her coping with shame. "One gets somewhat resigned and withdraws (...) I think I bury myself down as much as I can and let it [the feeling] stay there."

In other participants there are specific couplings of shame in the experience of fear, although the affect experience is to an extent differentiated. For instance, when Hans experiences fear he is aware that he gets a racing heart, he sweats, and he gets nauseous. But he also describes a coupling with shame:

> I do think that if I were to fly, I would have been thinking more about how I should behave towards others, than the possibility that I could have crashed (...) I mean, I don't respect myself so much, so if I were to crash in a plane and get killed, it wouldn't kind of matter.
>
> (Hans)

Similarly, Trine describes herself becoming both fearful and shameful in scenes where she is talking with men, and both fear and shame are activated when being in large assemblies of people. But at the same time she mentions scenes where she is only experiencing fear (fear of illness and death), so fear and shame are still to an extent differentiated on the scenic aspect.

Experience of overwhelming fear in social situations

For most of the participants, social interaction scenes are dominating in fear. And in all seven participants fear appears to be experienced as overwhelming or near-overwhelming.

Hans mentions the following scenes making him afraid, all of them related to social interaction: going to therapy sessions, being out shopping, traveling by bus or train, holding

speeches, and people addressing him. Gunn too mentions only social interaction related fear scenes: meeting strangers, holding a presentation, and meeting old classmates.

And while social interaction scenes are dominating in fear, the experience of fear seems to be typically overwhelming or near-overwhelming. Nikolai describes an awareness of fear which borders on panic:

> P: My hands get clammy. And then I get, I actually loose some ability to act. There arise so many thoughts in my head…
> T: Yes, what thoughts?
> P: Well, 'this you won't fix'. That one is typical. 'Now I've put my head below water'. 'Now I've walked into…' It gives me a feeling of being cornered. 'Now I really have to break loose to get on', and that feeling is not very good (…) And the heart beats very fast. Sometimes I get such a [breathes], the breathing gets out of hand.
>
> (Nikolai)

When asked about the impact of fear, Nikolai describes himself becoming somewhat paralyzed. On the other hand, depending on the situation, he says he also can become very action-oriented. He illustrates this by referring to an incident in which he crashed his car but did not experience any fear until a while after the crash, when the situation was settled. He says he becomes angry at himself if fear makes him perform poorly in a social situation, for instance when interacting with a woman he is interested in. However, he says that earlier he pulled himself down in such situations, adopting a "looser-mentality." His coping with fear is characterized by strategies of suppression. He talks about trying not to let the affect impact on him and telling himself to "just relax, it will be ok." But he adds: "Sometimes this catches up with me and I get very insecure and nervous." He also asks himself: "Why should I let this impact on me?" Nikolai is not diagnosed with panic disorder (he has no co-morbid disorder to SAD), nevertheless his awareness of fear seems to be close to panic. Trine is also diagnosed with panic disorder and avoidant personality disorder. For her the awareness of fear seems clearly to be characterized by panic:

> P: I get stressed and nervous and my heart starts hammering and... Feel kind of afraid… no, not afraid, but I get… I get an unpleasant feeling inside my body. And then I start… have some hyperventilation (...) So

if it's bad, then I start to get such attacks. And then I guess I get dizzy and nauseous.
T: Yes. Do you think… is there something in relation to how you think and so on. I mean mentally, are there any signals there?
P: Yes, kind of, regarding death and such things, then I do get… then everything blends into each other in my head and it gets kind of mommy and daddy, and then I get, I kind of have to call someone. I get kind of, yes, 'help'.

(Trine)

For Trine the impact of fear is likely more overwhelming than for Nikolai. She talks about sometimes becoming angry at herself for not saying anything in the midst of panic. At other times she becomes resigned about herself and cries. She copes with fear by sometimes avoiding the fear-inducing situation or adopting a rejecting stance: "If I'm out and so on, and then suddenly get at a loss so that 'no, now I can't dance with anybody', then I either can go home or go to the toilet or stay there. Kind of hide. Or I can appear rejecting. Just being aloof and rejecting. Because I don't dare or manage to say anything." In addition to SAD and avoidant personality disorder, Hans is also diagnosed with agoraphobia without history of panic disorder. Nevertheless, his awareness of fear is similar to that of Trine:

P: No, I guess I feel I get a racing heart and...
T: A racing heart?
P: And I sweat a lot. I guess that's what I mostly recognize. It's kind of a feeling that this you kind of don't want to do. I get nauseous.
T: Yes.
P: I can get that, if it gets too bad. While in the military, I worried so much that I got ill.

(Hans)

Like Trine and Nikolai, Hans talks about becoming angry at himself when experiencing fear and panic. He says he becomes angry at himself because he never learns that the things he fears are not so dangerous after all. And his coping with fear in a social situation seems to be characterized by an excessive self awareness and need for control:

P: Constantly thinks about what's going to happen, how you are to behave and all such things.
T: Hm.
P: If you're going to travel by bus or train, then you just go and think about what can happen, how you should behave, how you should sit, how you are to speak if someone talks with you and… it's mostly like that.

(Hans)

Overwhelming and generalized feelings of guilt

In five out of the six participants where guilt is investigated, guilt seems to be experienced as overwhelming. And in four of the participants guilt seems to be generalized to many more situations and occurring more frequently than would ordinarily be expected.

Being overwhelmed by guilt

Nikolai exemplifies the overwhelming impact of guilt that characterizes the participants:

It's very much a paralyzation, very much so. And it makes me kind of ill at ease, it makes me depressed too. Makes me very uncertain, makes me getting out of balance, very much so.

(Nikolai)

Nikolai tries to deal with this overwhelming impact of guilt by controlling himself. Sunniva describes the impact of guilt like this:

It presses med down and together, it makes me very small (…) It kind of doesn't make me stand forth (…) It gives me a poor posture, it doesn't make me straight and erect.

(Nikolai)

It is not revealed in the interview how Sunniva copes with this impact of guilt, but she says that she never shows guilt to her family, whether with words or non-verbally. To do so would be a "burden for my mother and father," she says.

Generalized feelings of guilt

In several of the participants, guilt seems to be generalized to a wide variety of situations and being experienced frequently. For instance, Sunniva describes the following scenes making her feel guilty:

> Yes, that's probably most things in this world (…) I've got a lot of that (…) I feel guilty for not making the time suffice so that I for instance could have helped mum more, so that I could have kind of been a better daughter for her now that she needs help (…) I feel that I…I have guilty feelings because I constantly feel that I don't reach what's expected of me, and that adds up to a few things.
>
> (Sunniva)

Nikolai shows a similar generality in what makes him feel guilty:

> Yes, that's a lot. Things I should have done that I haven't done, things I should not have done that I have done. Things I've said, yes, a lot of such things that give me a very bad feeling about myself. A lot in that area… and also that I feel I… I don't want to withdraw so much, I rather want to be a lot more out. And therefore I give myself such a bad feeling about myself on that.
>
> (Nikolai)

Janne describes some specific scenes making her guilty. That is, not keeping an appointment and postponing something she does not want to do. In addition to this, she talks about being stuck in feelings of guilt in relation to her family:

> Often when I (…) should have been doing something for them, maybe I should have helped them a little, with on and off and… My family kind

> of need the help I can provide, then I get kind of guilty for not being there for them, and maybe I enter too much into their private life if I do help them.
>
> (Janne)

Janne feels guilty whatever she does in this situation and does not seem capable of evaluating what would be a reasonable way of relating to her family-members when they might be in need of help. It seems as if she is almost in a constant state of guilt in relation to her family because of this uncertainty of whether to help or not.

Disturbance of self-assertiveness in anger and interest

It appears that an important theme across the nuclear scripts is the disturbance of self assertiveness, primarily by means of interferences and couplings by shame, fear and guilt. According to differential emotions theory (Izard, 1991), anger and interest are central motivating components of self-assertiveness. Anger gives strength to self-demarcation and mobilizes to self-defense. Interest is also related to self-assertiveness, if not to the same extent, or in the same manner, as anger. Anger seems to be especially problematic for the participants, both regarding the experience and the expression of anger. In interest it is mainly the expressive aspect which seems to be disturbed.

Disturbance of self-assertiveness in anger

In all seven participants the experience and expression of anger is significantly disturbed. It is reflected in poor awareness of anger, couplings of other affects into the experience of anger, suppression of the experience of anger, and withholding of emotional expression due to fear of rejection and feelings of guilt.

Poor awareness of anger. Although all the participants are able to mention relevant anger scenes, the majority have a poor awareness of their feelings of anger. So when Nikolai tries to describe his awareness of anger he mentions the following awareness signals: “not joyful,” “don’t smile,” “gruff and sour,” “want to be alone,” “withdraw,” “uninterested in things,” “thinking that I should confront immediately.” Neither of these awareness signals are clearly relevant for anger, with the possible exception of gruff and sour, but these are more synonyms of anger than specific bodily or mental awareness signals. Similarly, Gunn describes her awareness of anger as “bad mood and bad shape (…) I guess I go and exhaust

myself a little within." And describing her awareness of anger, Janne says that "it curls a little inside of me (…) easy to talk, easy to speak up about it."

Contrast this with Sunniva, one of the three participants with at least one relevant anger signal. She mentions the following awareness signals, where several of them are relevant for anger: "get a little agitated," "gives more energy," "waking up," and "ranting and raving a little." However, guilt seems to sneak in here, and she mentions that she becomes aware of "a gnawing feeling in the diaphragm." Actually, in all three participants with relevant awareness signals of anger, guilt is coupled in.

Couplings of guilt, fear and sadness in the impact of anger. With this degree of disturbance in the awareness aspect of experiencing anger, it is not surprising that the tolerance aspect also clearly is disturbed across all seven participants. Varying across the participants, the impact of anger is coupled with feelings of fear, guilt and/or sadness. Kjell describes the impact of anger as: "Get shaky, eh...warm, can get nervous." Janne says "it's not anything nice" and "I get sad" about her experience of anger. Gunn says, referring to the experience and expression of anger, that "it is not anything good, it isn't. It can make you become guilty too, because one feels one has been unreasonable."

Suppression and withholding of expression in anger. All seven participants talk about how they are suppressing the experience of anger and withholding its expression in an interpersonal context. Nikolai gives a telling description of the conflict of experiencing and expressing anger in interpersonal relations, finding instead a safe outlet when alone:

> P: Usually, when I was younger, I've been exercising a lot. I've taken out extreme amounts of anger and aggression in exercise.
> T: That has been your valve.
> P: Yes, and to such extremes, I've been doing insanely amounts of exercise. Not just because I want to get it out, but also because I enjoy it, but it has been much about taking out anger too.
> T: Because you have a lot to be angry about?
> P: Yes. And then I reproach myself for doing that, and then I exercise even more for myself.
>
> (Nikolai)

Perhaps Gunn gives an even more vivid description of this conflict, describing her coping with anger by the use of an axe at a time she was living in the same house as her mother-in-law:

> P: When I had had enough I went out and cut up a decent pile of wood.
> T: Mm.
> P: In order to let off some steam.
> T: Mm.
> P: But now, well I don't think I do anything specific now.
> T: What do you think would've happened if you showed you were angry?
> P: Well, then they would get a real shock.
>
> (Gunn)

So in their own ways, Gunn and Nikolai abreact in a non-interpersonal context, where nobody will be harmed or affected.

Fear of rejection if expressing anger. For the majority of the participants it seems that a central motivation for withholding the expression of anger is fear of rejection. Kjell gives an account of this fear:

> P: Fundamentally, I'm afraid of getting a negative stamp from my leaders, because I don't really have much education (...) so you have to find something that compensates for this, and through this job that I have now, it's important to keep a straight face (…) Then I have to be so called perfect.
>
> (Kjell)

He expects that if he shows anger and later applies for a new job, the reference he will get from his boss will be as follows: "Yes, he is somewhat unpredictable, he reacts quite a lot." From the extract above, it seems that Kjell's fear of rejection from his leaders is related to a lack of self esteem and self worth. In other words, shame seems to be coupled in and disturbing his ability to express anger at work. Nikolai gives a similar description of his fear of expressing anger:

> I'm not a violent person, I don't hit people or anything like that, but I'm very afraid of what I might go on saying (...) And then I'm worried that when I do it [say something], I'll be confronted by it. And then I'm very anxious about not having an explanation, not having anything to hit back on (…) That is very painful. Therefore I've always been very afraid of the confrontation part. I don't think I've been arguing with anybody in several years. Only when I've been drunk.
>
> (Nikolai)

Nikolai apparently expects that if he expresses anger he will get a response which renders him speechless. Clearly, shame is also coupled in here. Nikolai probably fears to be shamed and at the same time rejected if he expresses anger.

It almost seems that some of the participants are ready to grovel to avoid rejection. Sunniva says: "I can even try to please people I might be irritated at (...) I'm very preoccupied about making everybody like me."

Feelings of guilt if expressing anger. Guilt also seems to be coupled in for several of the participants, making them completely withhold the expression of anger. Explaining what it is like expressing anger verbally, Gunn says: "I think it's hard to say anything about it (...) I think it results in getting a bad conscience for being angry." Similarly, Nikolai says he is "afraid to hurt someone" if he shows anger. Recall that Nikolai and Gunn described abreacting their anger by exercising and cutting up wood, respectively. And previously it was shown that for the majority of the participants, guilt is generalized to a wide variety of situations and experienced as overwhelming. It is quite clear from the extracts above that guilt has a prominent position in disturbing the experience and expression of anger in the majority of the participants.

Disturbance of self-assertiveness in interest

In interest there also seems to be a significant disturbance of self-assertiveness in all six participants where this affect is investigated. In interest, awareness of the affect seems to be far better across the participants than in anger. The impact aspect of tolerance in interest is also not coupled with other affects to the same extent as in anger. The primary problem for the participants seems to be in the coping and expression of interest. And here, couplings of

fear, shame and guilt seems to be involved in a similar way as in the coping and expression of anger.

Although the impact of interest is generally regarded as pleasant and positive for all the participants, different kinds of conflict arise when deciding how to cope with the feelings of interest, and how to express them. It seems that interest is avowed as a motivating self-signal for the participants, but that sharing these feelings with others is dangerous. For Nikolai interest makes him becoming active, goal-oriented and engaged, and he regards it as a good feeling. However,

> Sometimes I'm afraid of being over-enthusiastic (…) I'm not really the one who is over-enthusiastic. But when I happen to be that I'm very afraid to make some blunders. I've kind of kept a distance, because I feel that now there is someone who pulls me away from what is interesting (…) It might be that there are sanctions to it.
>
> (Nikolai)

He further describes what might be the basis of this anxiety:

> I feel that I sometimes have an explanatory weakness, to put it that way. And then I withdraw, I don't like that.
>
> (Nikolai)

It seems that fear of rejection based on a low self esteem and a sense of inferiority prevents Nikolai from expressing his feelings of interest. In other words, shame seems to disturb the expression of interest for Nikolai. Similarly, shame is also disturbing the coping and expression of interest for Sunniva. She talks about it being problematic to express interest towards her colleagues because: "I never feel I have wiser things to come up with than the others." And she does not express interest towards her family, "because I assume that it is not of interest for them." For Janne the experience of interest is actually dominated by feelings of anger, as her main interest is observing unfair treatment of other people. This apparently generates anger within her and she says

> I'm a little afraid of getting too angry, because I was more angry when I was younger and I kind of try to put it more behind me (...) I try to exercise restraint so that I don't get so angry.
>
> (Janne)

Guilt seems to be coupled in here and preventing the expression of interest-anger.

Interest is avowed as a motivating self-signal, since the participants largely allow themselves to experience interest. This contrasts with anger, where for most of the participants even the experience of anger is conflict-laden. However, the participants have similar difficulties in expressing anger and interest, which indicates that in relation to others, interest and anger are not avowed.

Disturbance in the communication of vulnerability and tenderness

The fourth major theme revealed in the analysis was a disturbance in the communication of vulnerability and tenderness. Within this theme we have identified three sub-themes: 1) disturbance in the communication of fear; 2) disturbance in the communication of sadness; and 3) disturbance in the communication of tenderness.

Disturbance in the communication of fear

All participants withhold their expression of fear. It seems that a fear of rejection and an expectancy of becoming ashamed is what motivate this withholding of expression. Nikolai explains that he does not like expressing fear and that

> I then have a feeling that I express myself weakly. That there is a kind of weakness within you, you see?
>
> (Nikolai)

Similarly, Kjell states that it is "painful to kind of expose yourself." Gunn says she tries to hide her expression of fear but "how successful I am with that, I don't know." Illustrating this, she describes an episode where she felt that her brother had seen through her, correctly predicting to his wife that Gunn would not accept the invitation to a reunion party with her old classmates. Trine also tries to suppress her expression of fear although she feels, like Gunn, that she does not succeed in this. She says "I don't want to appear embarrassed and

nervous." Trine also expects that others will not speak with her if she appears like this. She actually refers to an episode where she overheard an acquaintance of her boss say: "Oh my god (…) there are nobody who bothers approaching and talking with people like that, who are sour and nervous." She explains: "Then I got kind of a shock. There are actually people thinking that they don't bother approaching such shy persons."

Disturbance in the communication of sadness

Six of the seven participants describe themselves hiding their expression of sadness in most situations. Like in the expression of fear, a fear of rejection seems to motivate this withholding of expression. Gunn explains that

> I think I try to hide it as much as possible, it is as if I have a mask no matter (…) But I probably get seen through, because I think it's noticeable all over me.
>
> (Gunn)

It is quite clear that Gunn also regards it as shameful to express sadness. Similarly, two other participants talk about distorting their expression of sadness to an opposite expression of happiness. It is as if these participants are putting on their happy mask when being sad. So Trine, referring to an episode at her job when a colleague exclaims to her that she always seems so happy in the morning, says: "If only she had known (…) I do maybe excel in hiding some things." And Sunniva says that "if I'm sad and sorry I don't bother going around and smiling so much, not to him [her boyfriend]," implying that towards others, she is showing a smiling face when sad.

Several of the participants quite clearly state that they fear rejection if showing sadness. Kjell says that he does not want to talk about being sad at his job because "I'm very concerned about (…) it not being passed on to my leader" and that he believes this will be used against him. Sunniva says that if she expresses sadness to her parents it will not be comprehended by them. She also mentions that the only occasion her sadness has been accepted by them was many years ago, when she was an inpatient at a psychiatric hospital.

Disturbance in the communication of tenderness

Communication of tenderness is also clearly disturbed across the majority of the participants. Here too, a fear of rejection seems to be a central motivation for withholding the expression. Nikolai explains that

> When it comes to tenderness and so on, I like that, I like sex and all this, that go without saying (...) But I then prefer to decide a little myself".
>
> (Nikolai)

He says that it might be too disclosing to show tenderness and further that "I want to show that I care about the person, but not too much." Feelings of shame might also be involved here. Actually, Nikolai refers to his father invading him with unwanted physical intimacy in his childhood, hugging him all the time. This might have been shame-inducing for Nikolai, contributing to his present conflicted feelings about tenderness.

Nikolai clearly is in touch with his feelings of tenderness despite the apparent conflict, and he is able to express these feelings at least in some situations. For others, experiencing and expressing tenderness is even more conflict-laden and difficult. Trine says that there are few things that make her feel tenderness and care. Except sitting next to her father in the sofa, only animals make her feel tenderness. And she has great difficulties expressing her feelings of care and tenderness to other people. Referring to the sofa scene, Trine says: "I'm not in any way rejecting then (…) but I just sit there." She further explains: "I would have liked to be more like that. But then I rather put up a mask so that I get kind of cold." At this point in the interview, Trine is moved and cries. We clearly see here a conflict between the need for closeness and tenderness, but at the same time a strong conflict in expressing these feelings. This conflict probably is related to a fear of rejection. And it is likely that shame is coupled in, as indicated by her statement that she puts up a mask of coldness instead of showing her true tender feelings.

Similarly, Gunn says that "it is a feeling I'm rarely in touch with, but it happens." Answering what it is like showing others tenderness and closeness, she says: "I probably have difficulties with that (...) I wish it had been easier for me to do that (...) there is a barrier on showing such feelings (...) I don't know if I'm afraid of being rejected." Even expressing tenderness to her husband is difficult: "It might be the case that one would like to give the husband a hug or anything (…) but it's not certain one does it even so."

Sunniva likewise explains: ”Just that thing about feeling tender, that’s a feeling I’m very uncertain about.” She talks about feelings of sadness that arise in her if she gives her parents a hug. However, she seems to be driven by guilt to give presents to people around her. She explains that after Christmas she has no money left, and further: “It can give me a feeling of emptiness afterwards, that I’m left with nothing.” So Sunniva has found a safe outlet for her feelings of love where she doesn’t have to physically touch the other or express her tender feelings verbally. But this is still not satisfactory for her, and she ends up feeling empty.

Paralyzing sadness

In six out of seven participants the experience of sadness is characterized by a coping strategy of withdrawal and/or strong suppression. And sadness is experienced as paralyzing for the majority of the participants. Clearly, it is very challenging for the participants to relate to this affect. It seems that there is a bridge or sequence between the disruption of central affective and interpersonal needs by the interference of shame, fear and guilt, and the activation of more or less paralyzing sadness. In this way, paralyzing sadness can be seen as the end-station in the nuclear scripts of the majority of the participants.

Poor awareness of sadness

Most of the participants have a poor awareness of sadness. For instance, Nikolai describes the following awareness signals of sadness: “withdrawing myself,” “getting in a bad mood,” “my body becoming heavy and drowsy,” “lacking in initiative” and “self-devaluating thoughts”. These signals seem to be more descriptive of a depressive state than sadness. Likewise, Sunniva describes the following awareness signals of sadness: “becoming very heavy and very empty inside,” “very passive,” “wanting to avoid responsibility,” and “lacking of energy and initiative.” Trine simply states that her body feels heavier. And Gunn says the feeling of sadness “probably is situated in the chest,” and she is aware of guilt-laden thoughts like “what has one been doing to make it like this.” So Gunn seems to give more a description of guilt than sadness, as a “feeling in her chest” cannot be considered descriptive of sadness.

Paralyzing impact and a conflicted coping strategy

Sadness appears to be experienced as overwhelming or near-overwhelming for six of the participants, and the coping strategy is accordingly characterized by active suppression,

and in some cases, withdrawal. Tellingly, three of the participants use the word “paralyzing” to describe the impact of sadness on them. So Gunn describes the impact of sadness as: ”A little paralyzing (…) it’s not a good feeling in any case.” She copes with sadness by ”trying to put it behind me as quickly as possible.” Nikolai is maybe even more paralyzed by sadness: ”It’s somewhat paralyzing (...) then you have a feeling that they can read you like an open book.” He copes with sadness by ”withdraw and watch TV for instance” and avoiding any focus on himself by ”talking about other things. Whatever, politics…” Trine does not use the word “paralyzed” to describe the impact of sadness on her, but referring to a recent scene where she did not get the apartment she wanted, she says: “I was just sitting there kind of in trance (…) in my own world.” The qualitative tone of this description clearly resembles being paralyzed.

The road to paralyzing sadness: perception of social deficits and social rejection

Six out of seven participants mention sadness scenes relating to social deficits and/or social rejection. For three of the participants, such scenes are completely dominating in sadness. Gunn mentions only one scene making her sad, namely “if one gets rejected”. Nikolai describes a number of scenes making him sad, almost all of them related to social deficits and social rejection. So for instance he explains that

> P: You can take being shameful and draw it to being sad and despaired. It gets a little… you get very inhibited. You get so despaired that it simply inhibits you.
> T: Do I understand you correctly, you say you are so despaired that you get shameful, or is it so shameful that you get despaired?
> P: Yes, both ways.
> T: Yes, shamefulness and despair blend somewhat?
> P: Yes, they do. To be despaired can be… for instance being shy also makes me despaired, because I’m not able to kind of overcome it.
> T: Basically, when you are not able to show who you really are, you get despaired?
> P: Yes, there it is.
>
> (Nikolai)

In this quote there is also an indication of an automatic feedback loop between sadness and shame, in that sadness is both a consequence and a cause of shame. Indeed, as shown in the previous section, several participants regard it as shameful to express sadness.

One of the scenes Trine mentions making her sad is her vocabulary. She does not extrapolate on this, but it is quite clear that she refers to a social deficit she perceives in herself. Hans explains that he gets sad when "you don't succeed in things" and when he is "going out with people." And one of the scenes Janne mentions making her sad is her job, where she says "I don't suffice." The perception of social inadequacy in sadness evident in these quotes also indicates that shame is coupled in here.

As described above, sadness is a very problematic affect for the participants, which make several of the participants paralyzed and most of them to engage in active suppression or withdraw. And by far the most salient source of their sadness is their perception of own social inadequacies and real or imagined social rejection. Related to this, in the previous section it was described how problematic it was for the participants to be self-assertive and to communicate vulnerability and tenderness. These real interpersonal difficulties probably contribute to their own perceptions of social inadequacy, which in turn activate more or less paralyzing sadness.

Summary of results

Five major themes were identified in the analysis. First, across all of the participants, overwhelming feelings of shame and fear are typically activated in social situations. However, in many of the participants there is a lack of clear differentiation in the experience between these affects. Second, most of the participants talk about feelings of overwhelming guilt that are generalized to a wide variety of situations. Third, there is a disturbance of self-assertiveness, especially evident in anger and interest in all the participants. This disturbance seems to occur at least partly by means of couplings of shame, fear and guilt. Fourth, there is a disturbance in the communication of vulnerability and tenderness in the majority of the participants. This disturbance also seems partly accounted for by couplings of fear, shame and guilt. Lastly, a central theme appears to be the experience of paralyzing sadness in the majority of the participants. For several of the participants this paralyzing sadness seems to be the result of their perception of felt social inadequacies and being of less worth than others. It seems that their difficulties in self-assertiveness and communication of vulnerability and

tenderness are also partly a reason for their experience of paralyzing sadness. A depiction of central relations between the major themes identified is presented in Figure 1.

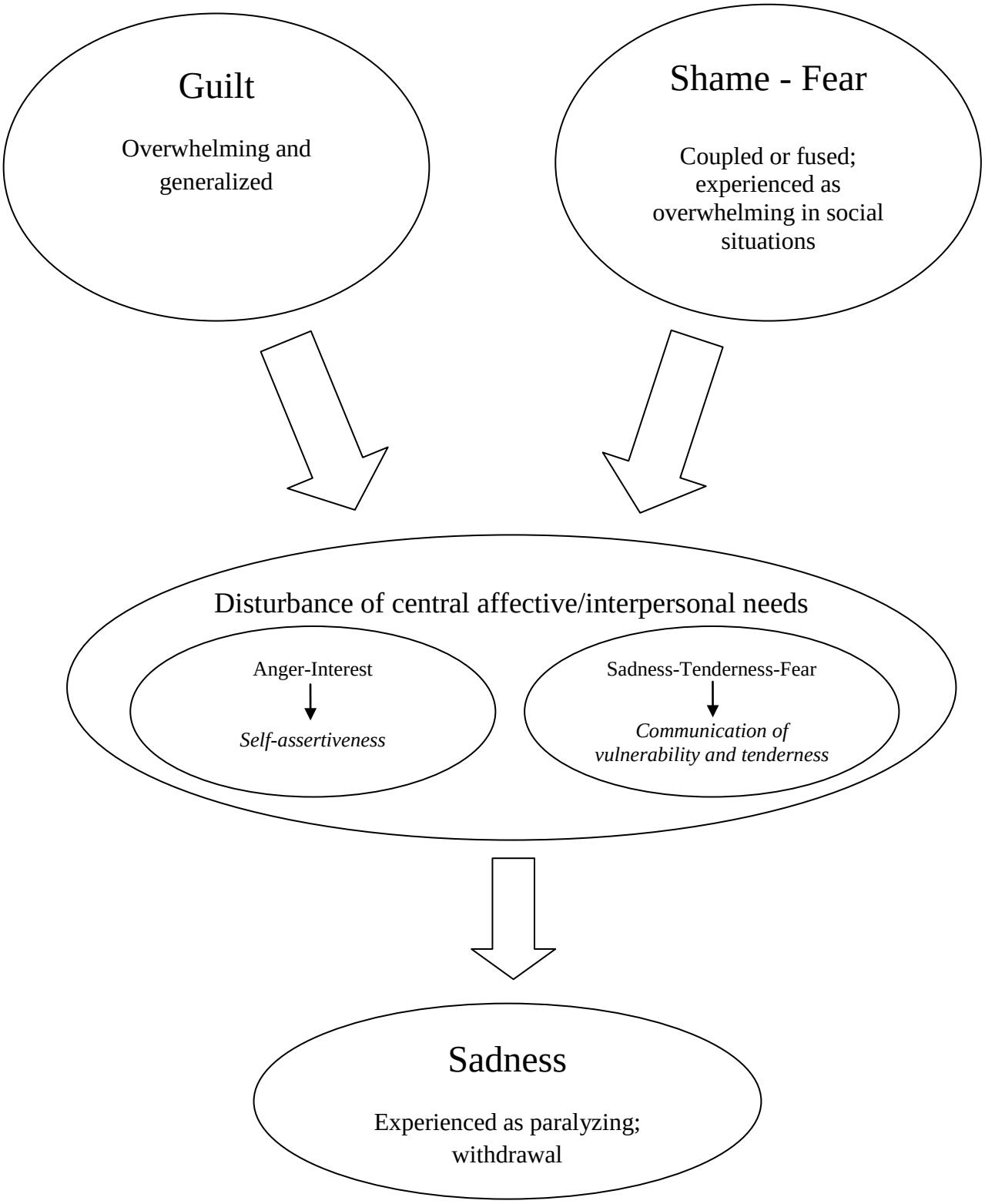

Figure 1. A tentative model of salient relations between the major themes identified in the analysis of affect organization in the seven patients with SAD.

DISCUSSION

This is probably the first study to explore organization of differential affects in individuals with social anxiety disorder (SAD). It appears to offer potentially significant insights into central affective processes operating in individuals diagnosed with SAD. The theoretical framework of the affect consciousness model (Monsen & Monsen, 1999) was applied when asking patients with SAD about their awareness, tolerance, non-verbal expression, and conceptual expression of nine discrete affects.

The first major theme identified was overwhelming or near-overwhelming feelings of shame and fear frequently occurring in social situations across all seven participants. That fear and shame appear to be centrally involved in social situations among the SAD patients studied here, is not surprising. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-R, American Psychiatric Association, 2000), the essential feature of SAD is a "marked and persistent fear of social or performance situations in which embarrassment may occur" (p. 456). The second defining feature of SAD in the DSM IV is the provocation of an immediate anxiety response when exposed to a social or performance situation, which may take the form of a situationally bound panic attack. As such, this study validates this aspect of the DSM IV conceptualization of SAD. However, the present study goes further by providing a fine-grained analysis of how the participants experience and relate to their feelings of fear and shame as well as seven other affect categories. Some of the participants explicitly expressed that they experience a more or less ever-present sense of shame, and that social situations provoke more specific shyness. There were several indications throughout the Results that this probably was the case for the majority of the participants too, even if not stated explicitly. There appeared to be a complete lack of differentiation between the experience of shame and fear in some participants, and significant couplings between the affects in others. That the participants appeared to have problems in differentiating between fear and shame might be related to the overwhelming impact of fear and shame and a lack of effective coping strategies. According to the affect consciousness model, fear and shame are inherently adaptive affects, with shame related to group conformity and sensitivity to others' opinions, and fear related to self-protection from threatening or unpredictable stimuli. However, both affects are experienced as unpleasant and painful (Izard, 1991). The unpleasantness of fear and shame is likely experienced as so strong in these participants that they lose the ability to cope with the affects, which further increases

their unpleasantness and overwhelming impact. The adaptive functions of fear and shame are thus lost.

This study has not explored developmental aspects of affect organization, but one may speculate in different kinds of attachment and learning histories contributing to the experience of shame and fear as overwhelming and disruptive. Several participants gave clues about possible sources explaining their poor level of integration of fear and shame. For instance, Nikolai described having a father who intruded him with unwanted physical intimacy in his childhood. It is also likely that individual differences in emotionality (i.e. frequency and intensity of emotional experience), which is partly genetically based, has a role to play in contributing to shame and fear being experienced as overwhelming and disruptive among the participants.

As this study is not comparative it does not say anything about the specificity of the role of shame and fear in SAD in relation to other psychological disorders. At the same time it certainly does not contradict Hyde's (2003) finding that shame plays a unique role in social anxiety relative to generalized anxiety. The fact that the DSM IV assigns a unique role to embarrassment in SAD, and that the centrality of shame is confirmed in the present study, also suggest that shame might play a more central role in SAD than in other psychological disorders. This study was part of a larger project on affect organization and psychopathology, and in the future the specificity of the role of shame and fear in SAD can thus be compared with other disorders.

The second major theme identified in the study was overwhelming and generalized feelings of guilt. There is no mention of guilt in the diagnostic criteria of SAD in DSM IV-R (American Psychiatric Association, 2000). We have neither found any study exploring the role of guilt in SAD. However, Tangney (1990) found that there was a strong correlation between a measure of proneness to experience shame and a measure of proneness to experience guilt. In light of this evidence, it may not be surprising that guilt seemed to be a problematic affect for the participants with SAD studied here, when it was already established that overwhelming shame was a central theme in the group. There is a debate in the affect and emotion literature on the relation between shame and guilt, with some viewing guilt as a variation of shame (e.g., Tomkins 2008a), while others retaining shame and guilt as separate basic affects (e.g., Izard, 1991). The AC model sees guilt and shame as separate basic affects. However, we recognize that they are similar in several respects, especially in their quality of self-consciousness and relation to the violation of standards (e.g., Leary, 2007). While guilt is typically elicited when violating a standard that is perceived as reflecting a specific behaviour,

shame is typically elicited when violating a standard that is perceived as reflecting the global character (Tangney, Miller, Flicker, & Barlow, 1996). On the basis of the present study, one may speculate that the overwhelming feelings of shame and worthlessness in the SAD participants result in generalized feelings of guilt. This might be because the overwhelming shame causes a disruption of self-experience and makes it more difficult for the participants to evaluate where one's reasonable responsibilities towards others start, and where they end. As shown in the Results, this uncertainty about where to draw the line of responsibility characterized Janne, who felt guilty whatever she did when members of her family might be in need of help.

A third theme that was identified in this study was a disturbance of self assertiveness in anger and interest, by means of couplings of shame, fear and guilt. We have not found any study exploring the relation of interest to SAD. But that anger is a problematic affect in patients diagnosed with SAD corresponds to two previous studies (Erwin et al., 2003; Moscovitch et al., 2008) that found that persons with SAD experienced more anger than controls, but at the same time had more difficulties expressing anger than controls. However, the present study went further in exploring other aspects of anger than frequency of experience and expressivity. Thus, it was found that the majority of the participants had a poor awareness of anger, with several participants unable to describe a single relevant anger signal. It was also found that the impact aspect of tolerance in anger was disturbed across all seven participants, primarily by means of couplings of other affects into the experience of anger. Varying across the participants, guilt, fear and sadness were thus automatically coupled into the experience of anger. Directly expanding on the studies mentioned above, it was found that all seven participants chronically suppressed their expression of anger, and that this appeared to be related to a fear of rejection and feelings of guilt.

A fourth theme identified in the analysis was how communication of vulnerability and tenderness was disturbed across the participants. We have not found any studies explicitly studying the expression of fear, sadness or tenderness in persons with SAD. However, Turk et al. (2005) found that persons with SAD, as assessed by self-report, are less expressive about positive emotions than controls, but found no differences between the groups with regard to expression of negative emotions. Their findings correspond to our finding of disturbance in the expression of tenderness, which is one of three positive affects in the AC model. However, the finding of Turk et al. (2005) that persons with SAD did not have difficulties with expressing negative emotions relative to non-anxious controls, does not correspond to our study, where the participants had great difficulties in expressing negative affects,

including fear and sadness. In the Results it was shown how especially shame seemed to be coupled in and inhibiting the expression of fear, sadness and tenderness in the majority of the participants.

Finally, a fifth theme identified in the analysis was the paralyzing impact of sadness in the majority of the participants, which seemed to be a consequence of the perception of own social inadequacy, as well as the perception of real or imagined social rejection. We have found no previous studies exploring the role of sadness or despair in SAD. However, that sadness is experienced as paralyzing among several of the participants in this study seems to be consistent with the much-cited finding that SAD and major depressive disorder (MDD) share the affective feature of low positive affect (Brown, et al., 1998). Although none of the participants in this study had co-morbid depressive disorders, the high co-morbidity between SAD and MDD is a well established fact (Watson, 2005). It is tempting to speculate that the presence of severe social anxiety as witnessed in patients with SAD, is one significant causal path that can lead to clinical depression. Several of the participants in this study appeared to frequently be in an affective state that resembles depression, as reflected in their experience of sadness as paralyzing. It is not unlikely that some of the participants were on the brink to actually fulfill the diagnostic criteria of MDD.

The affect consciousness model posits that aspects of affect integration are centrally involved in psychopathological processes. It is clear from the Results that these aspects of affect integration were important in explaining the functioning on different affects across the participants. For instance, the awareness of fear in several of the participants was characterized by signals of extreme intensity, such as hyperventilation, dizziness, sweating, a racing heart etc. Further, the impact aspect of tolerance in fear was characterized by being overwhelming in these participants: Trine said that she sometimes gets so resigned about herself when she experiences fear that she starts crying. And Nikolai stated that he can get paralyzed by fear to the extent that he is unable to act. The coping aspect of tolerance for these two participants was characterized by different strategies for avoiding this painful impact of fear: Trine might avoid the situation by going to the toilet, or distract herself by doing something if she wakes up with panic during the night. Nikolai explained how he tries telling himself to relax and to not letting the fear impact on him. An intriguing question is how the affect integrating processes of awareness, impact, and coping are represented in the brain in patients with SAD. There is already a fair amount of data on neurobiological correlates of emotion regulation in non-clinical populations. Ochsner and Gross (2005) reviewed studies that have explored the neural bases of controlling attention to and

cognitively changing the meaning of emotionally evocative stimuli. These aspects of emotion regulation correspond to the awareness and impact aspects of the affect consciousness model. They showed how different aspects of emotion regulation appear to be related to the functional activation of different locations in the prefrontal and the orbitofrontal cortex. Studies will probably soon explore the neurobiological correlates of emotion regulation in SAD and other anxiety disorders. Referring to the affect integration perspective, it would also be interesting to explore how the awareness and coping of *differential* affects are represented in the brain of patients with SAD.

As argued in the Introduction, the research paradigm within SAD that comes closest to the AC model is Mennin and colleagues' studies of emotion dysregulation in SAD (Mennin et al., 2009; Turk et al., 2005). They found evidence for emotion dysregulation in SAD in all four domains of their model: heightened intensity of emotions (only in the Mennin et al. (2009) study), poor understanding of emotions, negative reactivity to emotions, and maladaptive emotional management. These findings are important, and they are some of the first data to elucidate affective processing in SAD. However, the theoretical differences between this research paradigm and the affect consciousness model are significant. The most obvious difference is the global versus differential affect perspective characterizing the models. Mennin and colleagues have not studied emotion regulation of differential affects, but restricted themselves to the study of positive versus negative affect. Actually, in practice they also have not considered positive affect, since the measures they have used only take into account dysregulation of negative affect (Mennin et al., 2009). We believe that differential affects represent a significant factor in explaining psychopathology, and it would be interesting to see the results of studies of emotion dysregulation in SAD that took this view into account.

As also discussed in the Introduction, this study shares significant theoretical and methodological characteristics with Fox (2009), who studied the role of basic emotions in patients with anorexia nervosa. Using a qualitative methodology similar to ours, he found that three affects (or basic emotions in his terminology) seemed to be central in this group, namely anger, sadness, and disgust. For the anorexia patients, anger was experienced as "toxic" and was almost automatically suppressed. Actually, eating disorder symptoms seemed to be a way for the participants to cope with the experience of anger. Sadness was also a challenging affect for the anorexia patients, and the expression of sadness was similarly suppressed. The experience of sadness was believed to be a sign of weakness for the anorexia patients. For some of the participants there were couplings between anger and disgust, and Fox discussed

how it seemed that disgust towards their own bodies was used to suppress the more toxic feeling of anger.

Clearly, there are several similarities in the results of Fox (2009) and our study. Sadness and anger were also central affects among the patients with SAD in our study. But theoretical differences between the studies prevent a direct comparison. Building on a cognitive theory of basic emotions (Power & Dalgleish, 2008), Fox investigated only five affects: anger, sadness, fear, disgust, and happiness. With the exception of disgust, the version of the AC model used in this study takes into account these affects, but also adds shame, guilt, envy/jealousy, interest, and tenderness (Monsen & Monsen, 1999). Also, Fox (2009) did not systematically examine predetermined theoretical aspects of affect, as we did with regard to awareness, tolerance, non-verbal expression, and conceptual expression. Nevertheless, it is highly significant that both studies identified anger and sadness as appearing to be of central importance in SAD and anorexia nervosa. This supports the claim that differential affects represent an important factor in psychopathology. In this context, it is also interesting to note that the co-morbidity between SAD and the eating disorders is quite high. In one large study on the co-morbidity between the anxiety disorders and the eating disorders, SAD was present in 22 % of the individuals diagnosed with anorexia nervosa. Only obsessive compulsive disorder had a higher co-morbidity rate with anorexia nervosa (Kaye, Bulik, Thornton, Barbarich, & Masters, 2007). It is not unlikely that common affective processes may partly account for this degree of co-morbidity between SAD and anorexia nervosa.

Potentially, this study can contribute to the development of a vulnerability model of SAD that takes into account affective processes. At present, no such vulnerability model of SAD has been published to the knowledge of this author. A vulnerability model based on evidence regarding central affective processes in SAD might also contribute to the development of more effective treatment interventions for SAD. At present, specific treatment models for SAD mainly take into account cognitive aspects of SAD, such as unconditional negative beliefs about the self and excessively high standards for social performance (e.g., Clark & Wells, 1995). However, several general treatment models exist that are based on a differential affects perspective. In the future, these treatment models can potentially be adapted to specific psychopathological conditions where characteristics of affective vulnerability have been established. One such treatment model is based on the affect consciousness model (Monsen & Monsen, 1999). This treatment model takes into account differential affects and the aspects of affect integration mentioned above. Outcome studies have established its efficacy in the treatment of several psychological disorders, including

personality disorders and somatoform disorders (e.g., Monsen & Monsen, 2000; Monsen et al., 1995a). Similarly, Greenberg and Paivio (1997) have developed a treatment model they call emotion focused therapy. They too regard the role of differential affects as central in psychotherapy. An interesting development in cognitive-behavioural therapy has been the adoption of Buddhist mindfulness techniques in some treatment models (Shapiro & Carlson, 2010). Here a central intervention is training to become fully aware of internal mental and bodily processes, including emotion and affect. Clearly, mindfulness is overlapping with the awareness aspect of affect integration in the affect consciousness model (Choi-Kain & Gunderson, 2008). So far, however, mindfulness-based psychotherapies have not taken into account a differential affects perspective.

This study has several limitations. Two particularly central limitations will be discussed her. First, the use of qualitative methodology makes the results more difficult to generalize than in quantitative studies using larger samples. While we can be certain that the results apply to *this* particular group (with other issues of validity not taken into account), they may not generalize to SAD patients at large. However, it was argued above that several aspects of the results either converge with existing knowledge on affective processes in SAD, or possibly also appear to extend on the existing knowledge. At the very least, this study opens up interesting venues for more specific research regarding affective processes in individuals with SAD. Second, this study did not compare affect organization in SAD with other psychological disorders or with people without psychopathology. Therefore, we cannot be certain of the specificity of the findings. As already seen, some aspects of affect organization seem to be shared with individuals diagnosed with anorexia nervosa. Since the rate of co-morbidity is generally high within the psychological disorders, it is not surprising that specific affective processes are shared between disorders. It will be an interesting venue for further research to explore converging and diverging affective processes between different psychological disorders.

In conclusion, in this study of affect organization in patients diagnosed with SAD, several significant patterns were identified across the group. Quite in line with the conceptualization of SAD in the DSM IV-R (American Psychiatric Association, 2000), the group was characterized with the experience of overwhelming feelings of shame and fear in social situations. A central finding across the group was also the overwhelming and generalized feelings of guilt, a characteristic which is not a part of the diagnostic criteria in the latest edition of the DSM. These feelings of shame, fear and guilt appeared to create significant disturbances in interpersonal functioning, as witnessed in their problems in

experiencing and expressing anger, and their problems in the communication of vulnerability and tenderness. A final central finding was the experience of paralyzing sadness, a characteristic which also is not reflected in current diagnostic conceptualizations of SAD, but that seems to be partly supported by other lines of data regarding affective processing in SAD.

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APPENDIX A

Example of an affect script schema

TENDERNESS / CARE Trine

↕ (conflict) ↓ (sequence within an aspect) → (sequence across aspects) ≠ (disruption) X (coupling) ∞ (fusion)

Scenes	Awareness	Tolerance	Non-verbal expressiveness	Verbal expressiveness
- Not much - Sitting next to my father in the sofa - Animals – almost more fond of animals than people, that's horrible, I think	*Bodily* - feel warm - feel a lump in my stomach *Mentally/bodily* - it's good *Mentally* - feel safe	*Impact* - It's good to have the feeling, I do need it X Sadness - I feel a loss *Coping* - I don't do anything with the feeling ≠ - If others come too close, I quickly withdraw *Signal function* - Perhaps that I need more closeness	≠ *Avowal* - It's hard to show tenderness, I rarely do it - I'm more avoidant - They would be very surprised if I suddenly had shown tenderness *Typical expression* - I cannot hug friends of mine - I just sit there	≠ *Avowal* - It's hard to speak about tenderness, I do it very rarely ↓ - I put up a mask instead and get cold [starts crying in the interview] - I want to talk about tenderness but I don't manage to - I don'know how others would've reacted, maybe they wouldn't handle it *Typical expression* - "Oh, how I miss somebody [a boyfriend]" I can tell friends
	4	3	1	2

APPENDIX B

Nuclear script schemas used in the across-case analysis

KJERNESCRIPT GUNN

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM∞REDSEL S1. Skjemmes over mannens oppførsel S2. Stå frem i sosiale sammenhenger	**SKAM∞REDSEL** *K* - Vondt i magen *K/M* - Ille berørt *M* - Lyst å stikke av	**SKAM∞ REDSEL** *V* ≠ - Veldig fælt, blir resignert og trekker meg tilbake *H* ≠ - Graver meg ned så godt jeg kan - Gjør ikke noe med F, er der til den går bort igjen - Fortrenger alt så godt jeg kan *SF* - X Sky Overreagerer på noe jeg skulle reagert normalt på	**SKAM∞REDSEL** *Vedst.* ≠ - Ikke noe særlig, er avslørende om en selv *T.U.* - Prøver å holde maska i orden	**SKAM∞REDSEL** *Vedst.* ≠ - Vil jeg helst ikke - I så fall i ettertid, og da spøkefullt
SKYLD S1. Det meste S2. Min kritikk av mannens oppførsel	**SKYLD** *M* - Gjøre det godt igjen - X Tri Skuffet over seg selv	**SKYLD** *V* ↕ - Negativ virkning *H* - Prøver å gjøre det godt igjen - ≠ Prøver å grave bort F og bli kvitt den	**SKYLD** *Vedst./T.U.* ≠ Skjuler det så godt jeg kan, men det skinner kanskje gjennom	**SKYLD** *Vedst.* ↕ - Ikke problem tror jeg *T.U.* - Tror det ville være å be om unnskyldning om jeg kunne såre noen [Ikke troverdig uttr.]
TRISTHET S1. Bli avvist	**TRISTHET** *K* - Sitter i brystet *M* - ”Hva har en gjort for at det ble slik” - Deprimerende virkning	**TRISTHET** *V* ≠ - Er lammende - Tar bort energi *H* - X Sky Grubler på hva jeg skulle gjort og får skyldfølelse - Prøver å legge det bak meg	**TRISTHET** *Vedst.* ≠ - Skjuler det så godt som mulig - X Sky/Ska Har en maske uansett	**TRISTHET** *Vedst.* ↕ - Spørs til hvem, kan si det til mannen
SINNE S1. Når jeg blir utnyttet og føler meg dumsnill S2. Når barna ikke gjør det jeg ber dem om	**SINNE** *K/M* - Dårlig humør - Dårlig opplagt	**SINNE** *V* - Ikke god - X Sky Føler seg urimelig, får skyldf. *H* ≠ Sky - Vet ikke om jeg gjør mye med den - Før hogde jeg ved	**SINNE** *Vedst.* ≠ - X Sky Vanskelig å vise sinne, gir bare dårlig samv.	**SINNE** *Vedst.* ≠ - X Sky Vanskelig, gir dårlig samv.
ØMHET S1. En F jeg sjelden er borti, men det forekommer	**ØMHET** *K* - Lettere - Varm *K/M* - God F	**ØMHET** *V* - God F *H* ↕ - Kan være jeg får lyst å gi gubben en klem, men ikke sikkert jeg gjør det for det	**ØMHET** *Vedst.* ↕ - Har vanskelig for det, skulle ønske det var lettere - X Re Kanskje redd for å bli avvist *T.U.* - Gi gubben en klem	**ØMHET** *Vedst.* ≠ - En prater ikke om slikt, svært sjelden til mannen også - Min mann ville blitt forbløffet om jeg sa det

KJERNESCRIPT HANS

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM ∞ REDSEL S1. For alt som er til, meg selv hele tida (Ska) S2. Tre frem i sosiale situasjoner	**SKAM** *K/M* - Kjenner deg dårlig *M* - Ubetydelig og nedverdiget **REDSEL** *K* - Hjertebank - Kvalm - Sjuk av gruing *M X Ska* - Respekterer ikke meg selv - Tenker konstant på hva som skal skje og hvordan skal jeg oppføre meg	**SKAM ∞ REDSEL** *V X Si* - Sint på deg selv og trist, at en aldri kan lære [at det ikke er noe å være redd for] ↓ - ≠ Blir deprimert etter en stund *H ≠* - Holde meg borte fra folk, gjemme meg - Er slik [skamfull] hele tida, så vanskelig å bli kvitt F *SF* - Forteller åssen jeg er	**SKAM ∞ REDSEL** *Vedst. ↕* - Det viser jeg ikke, gjemmer meg - Vanskelig, for det er jo det sosiale jeg er redd for og da bør du jo skjule det mest mulig - Tror ikke andre ser det *T.U.* - Fryktelig lett for å rødme	**SKAM ∞ REDSEL** *Vedst. ↕* - Sier det svært sjelden *T.U.* - ”Er skamfull for at jeg ikke klarte det” - ”Dette har jeg ikke lyst til”
SINNE S1. X Ska Hvis jeg ikke får til ting S2. Hvis andre ikke hører etter S3. Er sint hele tida	**SINNE** *≠ Tri+Ska* *K* - Slapp og trøtt *K/M* - Deprimert *M* - Skuffa og forferdelig selvkritisk - Du burde klart dette, ellers er du ingenting - Tanker om å ta livet sitt	**SINNE** *V ≠ Tri* - Blir deprimert *H* - Prøver å kvitte deg med F [trolig depr.] *SF* - Forteller vel åssen jeg er	**SINNE** *Vedst. ↕* - Ikke noe problem, men vil ikke vise det til fremmede - X Ska A:”Er han riktig klok” kan de tenke *T.U.* - Ser irritert ut	**SINNE** *Vedst. ≠* - Ville aldri sagt det, men de merker det på oppførselen - X Ska ”Han er ikke helt god i hue” kunne de tenkt hvis jeg sa det
TRISTHET S1. X Ska Hvis jeg ikke får til ting S2. X Ska Tre frem i sosiale situasjoner (være ute blant folk) S3. Å tenke på framtida	**TRISTHET** *K ≠* - En slags influensa - Slapp - Kvalm - Vond følelse *M ≠* - Alt er håpløst - X Ska Du er ikke verdt noe, best om du var død	**TRISTHET** *V ≠* - Det ender opp i depresjon *H ≠* - Får meg ikke til å gjøre noe - Ligger i senga og tenker på alt mulig - Gjør ikke noe med F, går over av seg selv - F går over hvis du blir veldig interessert el. glad *SF* - F viser hvordan jeg er	**TRISTHET** *Vedst. ≠* - Det gjør jeg ikke, eller svært sjelden *T.U.* - Trekker meg unna på rommet, det ser de nok - Kan gråte for meg selv - Gråt en gang på klassetur, det var et helvete - X Ska A: De tenkte sikkert at jeg ikke var helt klok	**TRISTHET** *Vedst. ≠* - Fortalte om det i til læreren min, men det er vanskelig å prate om det

KJERNESCRIPT JANNE

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM S1. Føler meg i mange situasjoner underlegen S2. Sliter med skrive- og lesevansker S3. Sjenert for kroppen min, synes jeg er for tykk	**SKAM** *K* - Klump inni meg - Vondt i magen *M* - Ikke noe godt - Lyst å trekke meg tilbake og bli usynlig	**SKAM** *V* - Får lyst å legge hendene rundt meg selv – bli usynlig - Blir stille, tilbakelukket *H* ↕ - F må være der litt, men dyrker den ikke - Forsøker nok å kvitte meg med F, men ikke bevisst	**SKAM** *Vedst.* ≠ - Ikke lett å vise F - De som kjenner meg skjønner det nok *T.U.* - Veldig stille, tilbaketrukket	**SKAM** *Vedst.* ≠ - Kan si det helt unntaksvis - Husker ingen konkrete situasjoner *T.U.* - Sier det ikke med ord
SKYLD S1. Uansett hva jeg gjør blir det galt, stiller jeg opp trår jeg dem kanskje for nær, stiller jeg ikke opp får jeg dårlig samv for det	**SKYLD** *K/M* - Vondt - Uro *M* - Skulle ha gjort - Skal/skal-ikke-F - ”Hva gjorde jeg nå, var det galt eller riktig”	**SKYLD** *V* ↕ - Blir slitendes for mye med den, tar litt for mye av meg *H* ≠ - F sitter for lenge i meg uten at jeg får gjort hverken det ene eller det andre - Uansett hva jeg gjør blir det galt, enten jeg stiller opp eller ikke	**SKYLD** *T.U.* - Innesluttet og stille - Urolig, går frem og tilbake, føler meg dradd	**SKYLD** *Vedst.* ↕ - Kan si det, men ikke alltid jeg klarer det *T.U.* - ”Jeg har dårlig samv. for at du måtte vente”
SINNE S1. Når jeg blir tråkket på, f.eks. av sønnen hjemme S2. Når noen har gjort noe galt og ikke innrømmer det	**SINNE** *K* - Kruser inni meg *M* - Lett for å si fra	**SINNE** V ↕ - Ikke noe god stemning - X Tri Blir lei meg, ikke hyggelig å være sint *H* - Prøver å legge bånd på F og få den unna - Kan trampe i golvet	**SINNE** *T.U.* - Trampe i golvet	**SINNE** *Vedst.* X Re - Kan si det, men ikke direkte - Kan si fra hjemme, der føler jeg meg trygg - Kan delvis si fra i andre situasjoner og, men ikke så fullt ut *T.U.* - ”Det synes jeg var dumt”
INTERESSE S1. Se folk lide urett og har det vondt	**INTERESSE** *M* - X Si I første rekke tenker jeg ”åh, jeg blir sint” → - X Gla Glad hvis gledelige ting	**INTERESSE** X Si+Re *V* - Litt redd for å bli sint *H* - Dyrker ikke F så veldig - Prater med vedkommende som har med det å gjøre - Prøver å finne mer info om det	**INTERESSE** *Vedst.* ≠ - Synes det er vanskelig *T.U.* - Vet ikke hvordan jeg gjør det	**INTERESSE** *Vedst.* - Det går bra *T.U.* ↕ - Begynner vel å snakke om tingene

KJERNESCRIPT KJELL
↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM S1. Være sentrum for oppmerksomhet S2. At andre får kjennskap til at jeg går i terapi S3. Bli sett i en intim situasjon S4. Bli vippet av pinnen i samtaler	**SKAM** *K* - rød i ansiktet - flakkende blikk *K/M* - lattermild - X Re nervøs - ekkel og vemmelig F *M* - ønsker jeg ikke var her	**SKAM** *H* - ↕ Prøver å få kontroll, sette opp forsvar - ≠ Trekker deg unna	**SKAM** *Vedst.* ↕ - Ubehagelig, vil gjerne unngå å vise F *T.U.* - Le - Rød i ansiktet - Flakkende blikk - Alene: hyler og skriker	**SKAM** *Vedst.* ≠ - Det gjør jeg ikke - Men kommer det får jeg bare hoppe i det
REDSEL S1. Om barna kommer for sent hjem S2. Om konas fødsel starter før sykehuset	**REDSEL** *K* - rastløs - uvel og romler i magen *K/M* - klarer ikke sitte stille. går rundt meg selv - hjertet knyter seg	**REDSEL** *V* - Rastløs og utrygg *H* ↕ - Ikke redd frykten, kan leve i den - Må gjøre noe, orker ikke å tenke, vil ut av situasjonen - Vet ikke helt hvordan jeg skal håndtere det	**REDSEL** *Vedst.* ↕ - X Ska Smertefullt å blottstille seg - De ser det ikke så godt *T.U.* - Taus - Sliten	**REDSEL** *Vedst.* ↕ - Kan si det til nærmeste venner - Sier det lite til kona, vil ikke gjøre henne utrygg *T.U.* - Ryggen: gjøre det galgenhumoristisk
TRISTHET S1. At jeg er sykmeldt S2. Angst og depresjon S3. Skader og dødsfall blant nærmeste S4. Andre som blir urettferdig behandlet S5. Når andre blir triste	**TRISTHET** *K* - kroppen slapp - gråter *M* - tenker ikke rasjonelt - ”Hvordan kan jeg rette det opp”	**TRISTHET** *V* ↕ - Går hardt innover meg - Rastløs, må ha noe å gjøre for ikke å dvele *H* ≠ - Handlingslammet, blir sittende og stirre i veggen - Hvis det vedvarer orker jeg ikke å være i situasjonen - Hvis veldig trist prøver jeg å beskytte meg selv og de rundt - Holder F i sjakk der og da - Jeg vil ha kontroll og styring på livet i enhver smh.,det er det det handler om	**TRISTHET** *Vedst.* ↕ - Prøver å ikke vise det, men greit til nærmeste *T.U.* - Gråter - Snakker lavt - Tafatt	**TRISTHET** *Vedst.* ↕ - Kan si det til de nærmeste - X Re Sier det ikke på jobben, redd det skal brukes mot meg
SINNE - Urettferdig behandling og føle meg tråkket på	**SINNE** *K/M* - trykk-koker i magen jeg ikke slipper til *M* - sinne: ”pang” - ”er det noe vits å bli sint?”	**SINNE** *V* ↕ - X Re Blir skjelven og varm, kan bli nervøs *H* ↕ - Holder igjen, prøver ikke å reagere instinktivt - Ønsker å gå for å tenke gjennom situasjonen *SF* - Slipper jeg det løs er det egentlig ikke noe galt som vil skje, men har opparbeidet meg en sånn bli-godt-likt-holdning	**SINNE** *Vedst.* X Re+Ska - Redd for neg. stempel hvis jeg uttr. F - Viktig å holde maska på jobben, for har lite utdannelse og gjort det dårlig i skolen - Jeg må være perfekt *T.U.* - Likeglad, trekker meg inni meg selv - Smeller - Er høylydt	**SINNE** *Vedst.* ↕ - Prøver litt hjemme - Kunne sagt det hvis det ikke var neg. konsekvenser *T.U.* - ”Dette ble jeg irritert over” (til sjef om en annen scene)

KJERNESKRIPT NIKOLAI

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM ∞ REDSEL S1. Å tre frem i sosiale smh S2. Miste sosial kontakt S3. Bli avslørt, fortelle for mye om meg S4. Ting jeg har gjort (f.eks. i fylla), eller ikke har gjort (f.eks. ikke tatt kontakt med venner)	**SKAM** *M* - trekker meg tilbake og fåmælt - X Sky bebreider meg selv - X Re usikker og redd *K* - rødmer - kiling i magen - hetetokter	**SKAM** *V* - Blir stille - X Si Kan bli sint når andre kommenterer at jeg er sjenert - Da blir jeg mer skamfull - ≠ F setter meg ut, tar overhånd *H* ↕ - Prøver å overvinne, si at jeg ikke trenger å føle på det - Trykke ned, få kontroll *SF* - At jeg er en usikker person, det å være skamfull er en viktig del av meg	**SKAM** *Vedst.* ↕ - Føler meg svak hvis jeg viser skam *T.U.* - Rødmer - Tilbaketrukket - Halen mellom beina - Ydmyk	**SKAM** *Vedst.* - Kan si det - X Sky Be om unnskyldning hvis jeg har sagt/gjort noe dumt
	REDSEL *M* - mister handlingsevne - masse tanker i hodet *K* - klam i hender - hjertet slår fort - tar overhånd med pust - rastløs	**REDSEL** *V* ↕ - Handlingslammet, noen ggr. handlingsbevisst - X Si Sint på meg selv hvis det går dårlig *H* ↕ - Prøver å ikke la det gå inn på meg - Slipper ikke folk innpå meg (fra scener)	**REDSEL** *Vedst.* ≠ - Liker det ikke, gjør det av og til - Prøver å være ikke iskald, men uanfektet	**REDSEL** *Vedst.* ≠ - X Ska Liker det ikke, avslører en svakhet i deg - Andre vil lure på hvorfor du ble redd uten grunn
SKYLD S1. Ting jeg har gjort eller ikke skulle ha gjort S2. Føler dårlig samvittighet for alt og ingenting (fra redsel)	**SKYLD** *M* - X Si sint - X Ska jeg er dum, ikke god nok - inneslutta og fåmælt - X Tri trist *K* - ≠ lammelse	**SKYLD** *V* ≠ - Lammelse - Ille til mote - Deprimert - Veldig usikker - Sint på meg selv - Ute av balanse *H* ↕ - Gjør at jeg må veldig kontrollere meg selv *SF* ↕ - Veldig stor betydning for meg i neg. forstand	**SKYLD** *V* ↕ - Veldig vondt å vise - X Ska Avslørende	**SKYLD** *V* ↕ - Veldig vondt å si det - Men sier ofte ”beklager”
TRISTHET - At jeg ikke tør å være den jeg er pga alle de neg. F jeg har - Hvis jeg ikke når målene jeg setter meg - Min forklaringssvakhet	**TRISTHET** *M* - X Tri dårlig humør, trist og lei - X Si+Sky selv-bebreidelse - trekker meg tilbake *K* - tung og slapp i kroppen - kan gråte	**TRISTHET** *V* ≠ - Kan ta gleden fra meg - Lammende - Føler at andre kan lese meg som en åpen bok *H* - Trekker meg tilbake og ser på TV - Vil ikke at andre skal involvere seg - X Ska Unngå fokus på meg	**TRISTHET** *Vedst.* X Re+Ska - Prøver ikke å vise F, redd for å vise svakhet - Men får av og til kommentarer på at jeg ser trist ut, det er trasig - Redd for å bli satt merkelapp på	**TRISTHET** *Vedst.* ↕ - Sier helst ikke noe, men kan gjøre det - X SkaUnngå fokus på meg, snakke om andre ting - Vil ikke utlevere meg *T.U.* - ”Nå er jeg fortvila”

KJERNESCRIPT SUNNIVA

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKYLD ∞SKAM S1. Skyldfølelse for det meste her i verden S2. Føler til en hver tid jeg ikke når opp til det som forventes S3. Gjort noe feil/ moralsk forkastelig S4. Sjenert for å ta ordet på jobb el. i fam.sammenheng S5. At jeg er 36 og ikke har et velordnet liv S6 At jeg er utakknemlig og utålmodig overfor foreldra S7. Gir lett opp hobbyer for føler meg så dum (fra int.)	**SKYLD ∞SKAM** *K* - Klump i magen - Skyldfølelse - Føler meg dum - Føler meg truffet av noe - Selvfølelse lik ”null komma null” (fra mis.)	**SKYLD ∞SKAM** *V≠* - Trykker meg ned - Vil gjøre meg minst mulig *H ≠* - Prøver å skjule F - Unngår sosiale situasjoner	**SKYLD ∞SKAM** *Vedst. ≠* - Viser ikke F overfor fam., jeg vil ikke bli forstått *T.U.* - X Si Surhet	**SKYLD ∞SKAM** *Vedst. ≠* - Vil ikke snakke om F, blir ikke forstått i fam.
REDSEL S1. Tannlegen, sykehus og operasjoner S2. X Ska Møter og store forsamlinger S3. Pusten	**REDSEL** - Vondt i hodet,armer, mellomgulv og bryst - Hjertebank - Varm - Pusteproblemer - Anspent og urolig	**REDSEL** *V ≠* - Mister konsentrasjonen, F fyller hele hodet - Panikk for ikke å puste - X Tri+Si Først fortvilet, så forbanna, så ≠ tungsinnet *H* - Må ha noe i munnen hele tida - Må ha beroligende i veska *SF* - Forteller at jeg ikke er frisk	**REDSEL** *Vedst. ≠* - Skjuler F så godt jeg kan, andre sier jeg ser rolig ut *T.U.* - Har noe i munnen	**REDSEL** *Vedst. ↕* - Uttr. ikke F, redd for at det utløser panikk - Kan si til tannlegen at jeg er redd *T.U.* - ”I går hadde jeg det vanskelig”
TRISTHET S1. Jobben – usikker på egne avgjørelser S2. At jeg ikke får lov til å være frisk S3. Sykdom og døden	**TRISTHET** - Tung, tom og lite energi - Passiv og lite tiltakslyst	**TRISTHET** *V≠(?)* - Blir tom, tung og passiv - Bare lyst å være hjemme hvor det ikke stilles krav *SF* - Gir et bilde av hva jeg strever med og må jobbe med. Det er derfor jeg er her [i terapi]	**TRISTHET** *Vedst. ≠* - Ikke godtatt i fam. at jeg er trist - Men partner kan se det *T.U.* - Smiler ikke så fryktelig - X Si Surhet	**TRISTHET** *Vedst. ↕* - Ikke mange å si det til - X Si+Ska Kan si det, men vil oppfattes som negativitet og trolig ikke bli forstått

KJERNESCRIPT TRINE

↕ (konflikt) ↓ (sekvens innen funksjon) → (sekvens over funksjoner) ≠ (brudd) X (kobling) ∞ (fusjon)

Scener:	Oppmerksomhet	Toleranse	Emosjonell ekspressivitet	Begrepsmessig ekspressivitet
SKAM S1. Tre fram i sosiale sammenhenger S2. Menn S3. Nye steder og ting S4. Før fort veldig flau for alt jeg sa	**SKAM** *M* - Pinlig, "uff hva har jeg gjort" - X Tri Ser veldig stygt på livet *K/M* - X Re Litt sånn panikk *K* - Rødmer	**SKAM** *V* - Forferdelig - Blir ille berørt *H* ↕ - X Re Trekker meg unna for å unngå panikk - Prøver å snakke med denne personen	**SKAM** *Vedst.* ↕ - Ikke lyst å vise F *T.U.* ↕ - Tror selv jeg viser F, men andre sier jeg ser overlegen ut - Rødmer (fra oppm)	**SKAM** *Vedst.* ↕ - Kan si jeg er sjenert til venner, ikke til andre - Kan si unnskyld noen ganger, andre ganger vil jeg ikke innrømme det jeg har gjort *T.U.* - "Unnskyld, jeg overreagerte"
REDSEL S1. Døden og sykdom S2. X Ska Menn S3. X Ska Tre fram i sosiale sammenhenger	**REDSEL** *K* - Svimmel, kvalm - Hyperventilering *K/M* - Alt går i ett i hodet, hjernen blokkerer ut - Stum - Anfall - Stressa og nervøs - Ekkel F	**REDSEL** *V* - Urolig i kroppen - X Si Av og til sint på meg selv for at jeg ikke sier noe - X Tri Andre ganger så oppgitt over meg selv at jeg begynner å grine *H* ≠ - Unnviker situasjoner av og til, gjemmer meg - Når panikk sitter jeg fast og greier ikke å ta tak i F - Står opp og gjør noe hvis panikk om natta - Kan roe meg ned hvis jeg prater med noen jeg er trygg på	**REDSEL** *Vedst.* ↕ - X Ska Jeg vil ikke framstå som flau og nervøs - Andre vil sikkert ikke prate med meg da *T.U.* - Andre sier jeg ser overlegen og avvisende ut - Jeg føler jeg bare ser redd og stressa ut (Re)	**REDSEL** *Vedst.* ↕ - Det hender jeg sier det til venninner, men ikke til ukjente *T.U.* - "Jeg får hetta, det plager meg"
ØMHET "Veldig lite" S1. Sitte inntil far i sofaen S2. Dyr (nesten mer glad i dyr enn msk)	**ØMHET** *K* - Varm *M* - Godt - Trygt	**ØMHET** *V* X Tri - Godt å ha F, trenger det jo - Kjenner et savn - Klump i magen *H* - Gjør ikke noe med F - ≠ Kommer de for nært, trekker jeg meg raskt unna	**ØMHET** *Vedst.* ≠ - Vanskelig, sjelden jeg gjør det - De ville blitt overraska og nesten rygget hvis jeg viste F *T.U.* - Kan ikke holde rundt en venninne - Sitter bare der	**ØMHET** *Vedst.* ≠ - Vanskelig, veldig sjelden jeg gjør det - Setter opp en maske og blir kald - Er så fjernt for meg å snakke om sånt - Jeg vil snakke om det, men klarer ikke og gjør ikke det [gråter i int.] *T.U.* - Til venninner: "Å jeg savner noen"
TRISTHET - At jeg ikke fikk leil. jeg ville ha - Hvis noe skjer med familien	**TRISTHET** *K* - Tyngre i kroppen	**TRISTHET** *V* ≠ - Graver meg ned - Lett for å gi opp alt *H* ≠ - Sitter i sofaen, orker ikke gjøre noe - Kan sitte i transe i min egen verden - Mor sier jeg må tenke konstruktivt og finne på noe, men jeg lar F bare bli verre	**TRISTHET** *Vedst.* - Kan vise F overfor venner - ≠ Overfor andre ser jeg blid ut *T.U.* - Gråte	**TRISTHET** *Vedst.* ↕ - Kan fortelle det til de nærmeste - Sier ikke så mye, forteller om situasjoner *T.U.* - "Nå er jeg lei meg" - "Det er forferdelig