

Hidden Emotion Technique

By David Burns, MD¹

Hi group members, I have not yet seen the feedback from last night, but wanted to expand on the Hidden Emotion Technique, since we have not recently covered this method in group, and since many of you seemed to be unaware of it.

When you are treating anxiety, there are four powerful treatment models you can use:

1. The Motivational Model
2. The Cognitive Model
3. The Exposure Model
4. The Hidden Emotion Model

I use all four models with every anxious patient I treat because this gives me the greatest chance for a complete elimination of symptoms. If you use just one model, like Exposure, or just one school of therapy, such as CBT, or ACT, as so many therapists do, your success will be limited.

When, as we saw last night, a gifted therapist is stuck when using the Motivational, Cognitive, and Exposure Models in a skillful way, the Hidden Emotion Model will often provide the “missing link” in the treatment.

Hidden problems or feelings may be lurking behind the symptoms of any anxious patient, but are especially common with GAD, Panic Attacks, and OCD. They can even be hiding behind phobias, but not always—sometimes a phobia is just a phobia. But I have even seen this phenomenon with phobia patients—for example, a patient with the fear of flying.

The Hidden Emotion Model is also powerful and important in treating patients who go to medical clinics with complaints that have no medical basis—such as belly pain, headaches, chest pain, back pain, dizziness, or chronic fatigue. Dr. Alan Barbour used this approach for years at the Stanford outpatient medical clinic treating the “thick chart” patients. He wrote a book about this method called *Caring for Patients*. He reported that in about 50% of the patients coming to Stanford with unexplained medical complaints, bringing out the hidden problem led to a sudden and complete elimination of the medical complaint. He explained that the many patients had human problems, and not medical problems that could be addressed with blood tests, diagnostic terms, and pills. He did not call it the Hidden Emotion Method—that’s a term I made up years later, but I learned it from Dr. Barbour when I was a medical student. To this day, most medical doctors are not familiar with Dr. Barbour’s work, sadly.

If you want to learn more about the Hidden Emotion Technique, you can read about it in your reader, *Tools, Not Schools, of Therapy*, and I would encourage you to do that if you have not read that section of the book already. Your patients can learn about the Hidden Emotion Model if they are reading *When Panic Attacks* or *The Feeling Good Handbook*. You might want to assign one of these books as homework if you are treating an anxious individual, as this may accelerate the patient’s learning.

The Hidden Emotion Model is based on the idea that the great majority of anxious individuals are excessively “nice,” and this may be the cause of the anxiety. This means that when the patient is upset,

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he or she automatically sweeps the conflict under the rug, and loses sight of the event that triggered the anxiety. I call this phenomenon Emotophobia—or the fear of emotions. Last night, Daniele also used another term I coined called “Emotional Perfectionism.” You can also call it Conflict Phobia, or Anger Phobia. Regardless of what you call it, it happens so rapidly and automatically that the patient is almost never consciously aware that it has happened. All the patient knows is that he or she is suddenly obsessing or having a panic attack or worrying about things excessively.

The negative feeling or conflict that is hidden can be anything—it could be anger toward a family member, or unhappiness with one’s job, or wanting something you are not “supposed” to want. For example, a student may be pursuing a course of study—like engineering or law school—because of parental pressure, but may secretly be yearning for a different major or career, like art, or dance, or anything. But he or she may think that he or she “should” want to pursue the career that the parents favor. I saw this all the time when I was the referral shrink for the Penn Law School. Patients would come to me for panic attacks in class, or severe test anxiety, and thinking they might have to drop out of law school due to their anxiety. But in all cases, it turned out they had mixed feelings about becoming a wall street attorney, like the model they were seeing. Once they brought this to conscious awareness, and decided on a career track that was more appealing to them, the panic attacks disappeared. That is slightly over simplified, but is essentially correct.

Here’s another example. A woman came to me for treatment due to panic attacks at her job selling soda pop wholesale. The panic intensified every time her boss walked past her desk--she would experience a sudden and nearly uncontrollable urge to vomit on him, and often had to go to the lady’s room to lie down until the nausea passed. Sometimes she had to go home sick. And yet, she said she had the most wonderful boss in the world—he constantly sang her praises and gave her raises, and she thought the world of him. So her incapacitating panic attacks were puzzling, since she had no complaints whatsoever about her job.

I struggled with cognitive and exposure techniques for five or six sessions, but her improvement was only partial in spite of the fact that she worked hard and did her homework faithfully—just like the patient we learned about last night. And I was doing very good, high quality CBT, and I was receiving perfect empathy scores as well. But she kept getting sick at work.

At the seventh session, she suddenly confessed that she’d always wanted to design women’s clothing as a career, and she just didn’t want to spend her life selling soda pop, even though she was successful in her work. After the session she discussed the problem with her boss and husband, and decided to give notice and change her career. The next week, she told me that her panic attacks had suddenly disappeared, and we terminated the treatment the next week. I got a card from her six months later that she was still on a high and working happily as an apprentice to a woman who designed fashionable clothing for women.

Parenthetically, just before her breakthrough, she had explained that she had been identified as the “good daughter” when she was growing up. That meant always getting straight As in school, always being the class president, always working hard, even during summer vacation, and always pleasing people. Her sister was identified as the “bad daughter,” and got act out and do wild, fun things. But, when she read about All-or-Nothing Thinking, she saw these as very misleading labels, since her sister was really a neat and loving and wonderful person, and since she wasn’t always so “good.” Then I asked

her what she meant by not always being “good,” and she disclosed her desire to quit and pursue a different type of career.

The hidden emotion or conflict can be anything. Here are some hints that may be helpful:

- The hidden conflict is rarely or never buried in the past. It is buried in the present. It is usually something that is bugging the patient right now.
- The anxiety is usually a symbolic expression of the hidden feeling.

For example, I treated a woman who had had 55 years of failed therapy for constant obsessing and worrying about things. At the time she came to me for treatment, she had been worrying that her two sons—who had moved to a different state—would die in climbing accidents while hiking. She constantly fantasized that they would die horrible deaths in the wilderness, but simply couldn’t turn off the relentless and worrisome fantasies—much like the patient we discussed last night.

It turned out that she was secretly annoyed with her sons and uncomfortable with the women they had recently married, but felt she *should not* feel that way because she loved her sons and did not want to play the role of the wicked mother-in-law. After she brought this to conscious awareness, she spoke to her sons about her feelings in a loving way, and her worrying suddenly disappeared. The treatment only required two sessions, on two consecutive days. Something similar was going on in her relationship with her husband as well, so I worked with them as a couple for one session. She later told me that in more than 50 years of married life, they’d never once expressed any negative feelings, because they were both taught as children that if you love someone, you will never fight or argue. Once they opened up, they felt much closer, and her worrying finally disappeared.

A physician with a new baby came for treatment because he constantly obsessed that he would throw his new baby daughter over the railing at the apartment where he and his wife lived. He constantly fought these obsessions and tried to control them, thinking he was a horrible person for having them. Of course, his desperate attempts to control the horrible fantasies seemed to make them worse. He was in no danger of doing something violent—simply a patient with OCD and relentless worrying and obsessing, in his case violent obsessions.

It turned out he was overwhelmed with his life, constantly giving, giving, giving to his patients who were poor, working for a very modest income at a clinic in a dangerous neighborhood, and overwhelmed at home as well. He was perfectionistic, and thought he had to do everything super well, so he got almost no rest or recreation, working 80 hours a week. And now he was annoyed with having the burden of the new baby, but felt he was not *supposed* to feel that way. Once he expressed these feelings, he experienced immediate relief. But it was hard for him to do this at first, because he thought his feelings were so incorrect and wrong.

A medical student with OCD constantly obsessed that he was dying of AIDS. Prior to coming to me, he’d also had years of failed therapy for his OCD. When the obsessions flared up, he would read compulsively about the symptoms of AIDS, and finally go to our emergency room and insist on an AIDS blood test. Of course, these blood tests were always normal. That provided temporary relief but in a day or two the fear of AIDS would reappear. He had no valid reason to worry, since there was no wild sex and he was engaged and deeply in love with his fiancé. But he kept thinking that he MIGHT have stabbed himself

with a needle after drawing blood from a hospital patient with AIDS—and then forgotten that he'd done this.

The whole scenario was incredibly unlikely—but he thought, “It’s possible. And how can I know for sure?” Cognitive and Exposure techniques were only slightly helpful. Again, much like the patient we discussed last night.

One day, he called me on my pager in a panic on a Saturday, insisting he needed a blood test for AIDS. I asked what was going on, and he said his fiancé had just left to drive to New England for her high school reunion. He had stayed home in Philadelphia because he had to study all weekend for finals. I asked if he was feeling lonely or upset when she left without him. He said he was feeling that way, but “shouldn’t” because his feelings were irrational. After all, he said, it was “logical” for her to go and for him to stay home and study. So he was convinced that his feelings of loneliness and abandonment were inappropriate.

This is classic Emotophobia, and it is often the key to anxiety and obsessions.

Instead of ordering another blood test, I asked him to come in with his fiancé as a couple on Monday, after she'd returned home from the reunion. We did some simple communication training, and he opened up to her for the first time. He was afraid she'd reject him for his wimpy and irrational feelings. She, of course, loved his vulnerability, and they felt closer than ever at the end of that session. His OCD disappeared completely, and we terminated the treatment the next session, after doing some brief Relapse Prevention Training.

Once the patient has responded, and the anxiety disappears, I explain that the anxiety will return over and over throughout his or her life. I tell them that's a good thing, because they may never learn to recognize all their feelings in real time, although they will improve somewhat. So when they squash some emotion, their body will tip them off by creating anxiety again. So they can view the anxiety as a hint that they need to figure out who or what is bugging them. This is a nice way to reframe the anxiety if you've used the Hidden Emotional Model successfully. In other words, the anxiety becomes a good thing, something positive.

The medical student with OCD called me thirty years later. I had not heard from him the entire time, but it seemed like only two weeks had passed. He was now the head of cardiology at one of the top medical centers in the US. He was asking permission to use my anxiety inventory in his research on patients with unexplained chest pain, and I was thrilled to give permission, of course. I asked how his OCD was. He said it was exactly as I had predicted. He was totally symptom free 99% of the time. But every now and then his worrying about AIDS would return, so he would carefully review who and what had been happening recently so he could figure out what problem or feeling he was ignoring. Once he figured it out, he would express his feelings or deal with the hidden problem, and the anxiety would immediately disappear again.

When I am doing the Hidden Emotion Technique, I simply tell patients at the start and end of each session that they are probably hiding something from me and from themselves, and ask if they have figured out what it is yet. Here are a couple additional tips that might help the therapist and patient figure out what the hidden problem is:

- The anxiety will nearly always be something specific, a problem in the here-and-now, and will rarely or never be something general like anxiety about the phases or meaning of life. In fact, obsessing about the meaning or phases of life is a common symptom of anxiety, and not a cause of anxiety.
- The hidden emotion is never fear or anxiety. Those are the non-hidden emotions that the patient complains about.
- The hidden problem will rarely be unexpressed grief, although that could occur. For example, it will never be grief about the chronic anxiety. However, I saw unexpressed grief once at the Stanford medical clinic when working with a patient with six years of unexplained “dizziness.” All the previous doctors had asked about his medical symptoms, and he’d had \$80,000 worth of brain scans, heart tests, and so forth. In today’s dollars, it would have been more than half a million dollars in medical tests—but they were all normal. Dr. Barbour asked a different type of question when listening to the patient’s heart and lungs with the stethoscope. Dr. Barbour asked if the patient could remember what was happening when the symptoms first appeared. He said he could remember exactly—in fact, he was at his wife’s funeral when he first began to feel dizzy. Dr. Barbour asked if he had grieved a great deal over his wife’s death. He said no—he’d been holding his feelings in because he didn’t know if a man was supposed to cry. With Dr. Barbour’s encouragement, he began sobbing uncontrollably right in front of us for several minutes. Then he pulled himself together and said, “Doctor, my dizziness has finally disappeared. I’m not dizzy now.”
- The therapist can ask, “is it this” or “is it that?” However, the anxious patient will nearly always shoot down your hypotheses, which will often be incorrect. But even your incorrect guesses can help the patient bring the actual hidden conflict to conscious awareness.

Typically, it takes several weeks, and during that time the patient may insist that there is no hidden conflict or problem. So you have to keep the faith as a therapist. This is one technique that you may want to stick with, even when it does not seem to be working. When the patient suddenly discovers the hidden problem, after several weeks of denial, everything becomes really obvious, and I always tell myself that I *should have* figured it out sooner. But that’s just the way it works.

It’s a neat model. We don’t know if it will help last night’s patient, but it is certainly worth a shot and it’s a great technique to add to your therapeutic toolbox. I like the model for several reasons:

- The Hidden Emotion Model has great explanatory power. Anxiety doesn’t just come out of the blue, without rhyme or reason. It comes out of the human experience. When patients suddenly get anxious for “no reason,” there will nearly always be a reason—but it may be temporarily hidden from the patient’s conscious awareness. If the patient is worrying about his spouse or partner dying, he may be secretly angry with that person, or unhappy about his marriage, or something that’s going on in his marriage. But he may feel he “shouldn’t” have those feelings because he loves his spouse or partner. And if he is constantly worrying about losing his job, he may be secretly unhappy with his job, but may feel he *should not* feel that way because he has a good job and is well paid.
- The Hidden Emotion Model has great healing power and can get us unstuck when treating apparently resistant or persistent anxiety disorders. When patients deal with the feeling or problem they’ve been avoiding, you will usually see a tremendous improvement, and often a

complete and sudden elimination of all the symptoms of anxiety. So it is a model that can provide practical and real healing for many of your patients. It's not just some abstract theory.

- The Hidden Emotion Model shows us that the real cause of anxiety is the fear of the self, of who we are and how we feel as a human beings. In addition, in recovery, we are not simply overcoming an "illness" or "anxiety disorder." Instead, we are learning more about what it means to be a human being, and that it is okay to have feelings, even seemingly crazy and irrational ones, and to express them.

One last point. Last night a lot of wonderful ideas were proposed, including how to deepen the therapeutic relationship so as to make it more real. That's always a great thing to do, but that may not help with the Hidden Emotion Model, and may not lead to much improvement in the anxiety. A therapeutic relationship is important, of course, for many reasons, but will not itself bring about a cure for most patients. And we saw some strong evidence of that last night—the Therapist Empathy scores with this patient have been perfect. The therapist we worked with last night has been doing a fabulous job of that, and can certainly do more if she wants to. But the Hidden Emotional Model is a little different kettle of fish.

Finally, it is just one of maybe 20 or 30 techniques on your Recovery Circle. It will help 50% to 75% of anxious patients, in my experience, but it is just one method among many that have great promise, and sometimes will not help at all. Don't ever put all your eggs into one therapeutic basket!

David