A Psychodynamic Perspective on Anxiety

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To most psychodynamic psychotherapists, anxiety is not just another symptom, nor is it solely a cluster of disorders. Rather, it is a pivotal phenomenon in the complex psychic economy. To begin with, it is an affect—a more or less consciously experienced emotion. To the person experiencing it, it is a disquieting sensation—a signal that all is not well, that some kind of danger lurks—and hence it borders on fear without a distinct object of fear. It may or may not have the physiological concomitants of fear: tachycardia, palpitations, shortness of breath, diaphoresis, gastrointestinal hypermotility, muscle tension, insomnia, and more. Not understanding the psychic source of these symptoms may allow the anxiety to grow into overt panic—fear of death or catastrophic loss of control, the source of many needless trips to emergency rooms and negative cardiac work-ups. The eruption of anxiety into such distressing symptoms is a sign that defensive measures to ward it off have failed.

Yet managing anxiety is an important task for everyone. Some degree of anxiety is normal in many situations—before an examination, before giving a speech, before a medical test or procedure, before the big game, before a first date. Anxiety in a manageable degree can be a positive motivation to be more alert, more prepared, more focused and effective, just as it can impair performance when it is not managed well and it becomes overwhelming and paralyzing.

How does anxiety work?

The trail that leads to symptomatic anxiety starts long before the stage where anxiety becomes disabling. Perhaps there is a genetic predisposition, an innate low threshold for anxiety, since anxiety disorders run in families. Perhaps there has been difficulty in the early development of the neural pathways that manage and control anxiety. This may be attributable to interference with attachment and affect regulation in parent-child interactions early in life when critical steps in brain development are occurring, for we are learning that early life experiences as well as genetic makeup contribute to the formation of each individual brain, particularly its regulatory systems.[1]

In one of his most important papers, Freud set forth a hypothesis of how anxiety plays a pivotal role in the development of symptoms.[2] The locus of action is what psychoanalysts call the ego, shorthand for the wide-ranging collection of executive functions that record sensation, process information, access memory, form assessments, reach decisions, and command motor activity. Most important for purposes of understanding anxiety is the ego function of regulating affects.

In Freud's model as elaborated by later psychoanalytic studies of small children, the ego of a small child experiences anxiety in a variety of situations related to the stage of infant and child development. In work with adult patients, it is not hard to discern these various types of anxiety. In-depth psychoanalysis may relate them to difficulties in early childhood.

Very early in life comes the panic associated with needs for food or love not being met by a caretaking parent, as the infant seems to sense its helplessness and total dependency on the absent other. As the child becomes more active and mobile and aware of being a separate person, it may fear losing the care-taking "object." Then, with the appearance of control struggles and naughty behavior, there is a more comprehending fear of loss of the love of the object even without losing the object: "Mommy/Daddy won't love me any more because I've wet my pants." As sexuality enters the picture and the child develops curiosity about anatomy, early awareness of sexual feelings, and more complicated feelings about the parents, the child may fear retaliation through damage to the pleasure-giving genitals—historically referred to as "castration anxiety." This may be generalized to fear of harm to the body overall.

Approaching school age, the child's superego matures through internalizing the rules of behavior and develops morality, standards, and expectations for the self (the conscience and ego ideal.) The anxiety now shifts to a fear of another set of unpleasant affects—guilt, with its self-punitive aspects and shame in facing others. If the child has been punished harshly by his or her parents,

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the superego internalizes this and may become even more harsh in its administration of guilt and self-punishment, but the newly minted superego can be quite severe in any case until the child learns some balance and moderation.

This superego development has to do with regulating affects, but it also parallels the evolution of the child's awareness and understanding of the real world around him or her. He or she becomes less intensely motivated by what feels good at the moment (the pleasure principle) and more guided by what will work to achieve satisfaction in the long run through dealing effectively with the environment (the reality principle.) Problem-solving abilities and the ability to delay gratification become important ego strengths. Throughout these early stages, the child takes increasing pleasure in competence and mastery.

Conversely, overwhelming affect is experienced as terrifying and traumatic—truly damaging psychically and, as we now suspect, even neuronally. Having experienced great distress from anxiety at these various stages, the ego develops defensive measures to reduce the pain. It establishes an early warning system, sensing the potential for anxiety through minute sensations of "signal anxiety," which prompt evasive mental activity. Avoidance of anxiety thus becomes the prime motivator of psychological defense mechanisms.[3] The more primitive mechanisms are *projection* ("he is the one with evil intent, not I") and *introjection* ("rather than carry the guilt of killing him, I'll kill myself"). A ubiquitous defense mechanism is *denial* ("this chest pain doesn't mean anything important" or "I'm not really attracted to my neighbor's wife"). Traumatic experiences or very disturbing thoughts may be warded off through *repression*, banning access to their memory traces. More complicated defensive mechanisms are *turning passive into active* ("I'll dig the splinter out myself, Daddy") or *identification with the aggressor* (the victim who becomes the bully or plots violent revenge).

Some defense mechanisms are associated with particular symptom constellations. Examples are *intellectualization, undoing, and isolation of affect* in obsessive-compulsive personality disorder, or *displacement and avoidance* in phobias. By and large, defense mechanisms are unconscious, as are the impulses or thoughts that are warded off. Sometimes the warded-off impulse and the defense mechanism collude to express the impulse in a disguised, symptomatic way, as in the obsessively cleaned room that has a messy corner, or in the murderous rage that is enacted in suicide. Rarely are people fully aware of the multiple motivations and internal forces that result in final resolutions or actions.

Inherent in this formulation is psychic conflict—various parts of the personality that are at odds with each other or with the individual's perception of external reality. Love and hate towards the same person (conflicting drive impulses) create ambivalence. Sexual desire confronts moral prohibition (a superego function) or concern about realistic consequences (an ego function.) Chest pain and shortness of breath (reality) are at odds with a narcissistic vision of oneself as being in perfect health.

How is this model useful in treating anxiety disorders?

Treatment begins with careful diagnosis. Symptomatic anxiety can occur in severe mental disorders such as schizophrenia, major depression, or dementia, as the patient's ego confronts deteriorating mental function. Substance use disorders, in which the defense mechanism of denial is prominent and persistent, must be recognized and dealt with. Various endocrinological and metabolic disturbances that cause the sensation of anxiety must be excluded. Generalized anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, and posttraumatic stress disorder each have their own profile of symptoms and potential causes that may influence the direction of treatment. The patient's personality, level of maturity of ego functions, motivation for treatment, and circumstances will all influence the selection of treatments.

Strong evidence for biological factors—family history, intense and relatively non-situational anxiety, unresponsiveness to psychological exploration—points towards a primarily biological treatment with anxiolytics and antidepressants. Demand for a very directive, suppressive approach may favor the circumscribed insight and structure afforded by cognitive-behavioral therapy. Clear-cut evidence of current interpersonal difficulties or role changes may prompt a trial of interpersonal psychotherapy. The relative explicitness and simplicity of these treatments has made them amenable to randomized, manual-directed controlled trials that have established their credibility in the narrowly defined world of contemporary evidence-based medicine. But the application of all of these treatments can be enriched by awareness of psychodynamic issues, based on a century of accumulated clinical experience.

More specific data are emerging regarding the efficacy of psychodynamic psychotherapy with anxiety dis-

orders. Notable is Milrod's work with panic disorder, supported by a manual of panic-focused psychodynamic psychotherapy,[4] an open trial of which has yielded outstanding results.[5]

The powerful advantage of psychodynamic therapy is its openness to free association and exploration in partnership with the patient, without preconceptions as to the particular nature of the patient's difficulty. Under the influence of the life-long human drive to mastery, many patients deeply desire to understand the source of their anxiety, to confront their hitherto unrecognized inner conflicts and environmental challenges, and to grow beyond the need for years of dependence on medication to regulate their emotional states. With these patients, exploring their multiple emotions and motivations, recognizing entrenched ideas and compulsions to repeat traumatic situations, and accepting the presence of hitherto forbidden thoughts and feelings all lead to dealing with conflictual states of mind in a more conscious way with less of the nameless dread and anxiety that comes from not knowing or understanding.

Most psychodynamic psychotherapy does not have the duration or intensity to undo the ingrained difficulties with affective regulation that originated in very early life experiences. Full-scale psychoanalysis has a better chance of working through these difficulties and helping the individual achieve growth and mastery. However, it is helpful for patients to recognize how their processes of emotional regulation became what they are and to find compensatory means to improve their function. Ongoing medication or its prn availability may play an important supportive role with patients whose early attachment difficulties left them highly susceptible to anxiety or panic. Patients with severe obsessive-compulsive disorder may subdue the worst of their distressing thoughts and behavior with medication, while working to understand their roots in psychic conflict.

Not to be underestimated in the treatment of patients with anxiety disorders is the crucial nature of the treatment relationship. Patients with anxiety disorders often call their therapist's answering machine and find relief just in hearing their therapist's voice message. Clinicians need to give special attention to preparing these patients for breaks in continuity and provide assurance of the availability of help should they need it. The more secure the patients feel in the treatment relationship, the less likely they are to call. This acceptable and manageable dependency usually seems to remedy profound insecurity these patients have felt all their lives due to severe difficulties in being able to count on their parents to be there, physically and emotionally, for them as small children. In more severe cases, the treatment relationship goes beyond the "as if" nature of transference, for the therapist in reality fills a significant gap in the patient's emotional development. It is not a cure, but it is a powerful aid in the relief of suffering.

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