

PSYCHOTHERAPY OF ANXIETY STATES

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If I were to personify our psychiatric terminology, I would portray depression as an old man, the manic as an acrobatic court jester and anxiety as a prostitute—a prostitute, because she lends herself to all men, all functions, all diseases, all moods and all needs. Even as descriptive terminology, anxiety states are uniform only because a variety of phenomena are blended together into one semantic soup.

A popular way of defining anxiety is to contrast it with fear. Fear, it is said, is a reaction to an objective, real danger, while anxiety is diffuse, often without cause and not warranted by the reality situation. One difficulty with such attempts at definition is that we are using one and the same word for a large number of phenomena.

We have witnessed acute anxiety manifestations resembling panic that occur

when a person is unable to focus on the tasks confronting him due to inner preoccupation. These affect us quite differently than the high-pitched, colloquially called hysterical, tone of a person who insists he could not possibly do something, or who threatens suicide with a pressure resembling blackmail, hoping to get somebody to change an aspect of the situation. We have seen the well-established, phobic-like anxiety that concerns certain actions or situations which seem to be ritualized tabus of living, often connected with privileges that are insisted upon because one is anxious. We are all familiar with the great discomfort arising in a person who finds himself in a quandary because he has gotten into a situation he is unable to cope with due to certain personality constellations.

Our difficulty in pinning down the precise meaning of anxiety is, however, not only due to our lack of semantic subtlety. It has also been compounded by our conceptualizing anxiety as the prime motor

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in establishing neurotic functioning, in terms of the initial trauma that causes anxiety, the anxiety that establishes the pattern of defense and the anxiety that is the guardian of the neurotic defenses by means of sounding warning signals when danger is anticipated. We thus perceive anxiety behind every bush and, for example, will speak of an overly arrogant, overly obsequious or overly eager person as one who is really very insecure and anxious, although no outward manifestations are present.

In addition to all this confusion we have declared anxiety to be the emblem of our time. The present era, it is said, is the age of anxiety. The uprooting of tradition, the flooding of everyone with the most contradictory bits of information through our mass media, the confusing interdependence in world politics and our knowledge of possessing the tool for humanity's self-destruction—all this and more is cited to create the image of lost, alone, isolated man, who can find comfort only by facing up to these existential anxieties and consoling himself in his historical fate.

We too easily equate anxiety with basic helplessness since, very often, we deal with a phenomenon that has teeth as well as vulnerabilities, system as well as confusion. Most patients take to an image of themselves as basically helpless and mistreated as readily as ducks to water. They may find us, however, more sympathetic than helpful.

I have wondered why we have become so enamored with this helpless image when we talk of anxiety. A historical view may give us some perspective. With his marvelous ability to observe phenomena, Freud soon established that not all phenomena were spontaneous anxiety. He recognized that some anxiety reactions seemed to have a definite, purposive function. The function was a warning not to proceed with whatever one was about to do. But Freud also had a talent and genius for tying the observed into a grand over-all scheme. Thus he immediately deduced that this purposive anxiety was present only because it had been initiated by the memory of a feeling of helplessness in face of a potentially traumatic situation. Essentially, we have retained this reasoning. No mat-

ter how strongly manipulative a patient may be through his anxieties, how strong in imposing his preferences on others, we automatically regard this behavior as a defensive posture which shields the fundamentally helpless and frightened individual.

Clinical observation does not bear this out. Many a child will learn to control his mother by screaming. If the child is successful in getting his way he will become very good at this method of proceeding. And why not? Children will test the flexibility of our limits. This is not a response to anxiety. It is normal learning. This may not be very useful education and the child may get into trouble. All I wish to point out is that it was not insecurity and anxiety that started the particular willful behavior pattern.

NEED TO DEFINE AIMS

Psychotherapy has to have a model, a framework of proceeding just as other therapies do. Psychotherapy has tended to differ from medical therapeutic models by purposely disregarding the symptom. Instead, it has endeavored to unravel the mysteries of the whole personality structure. The reason for this has been that the initial symptoms were often the bridge which permitted a distressed person to come to a therapist but not the real focus of trouble. This intentional policy of noncommitment to changing any specific particular aspect of the patient's behavior has therapeutic disadvantages. I suggest that we also try to define our aim of change and thus mobilize the therapist's as well as the patient's efforts towards this enterprise.

Differential diagnosis is essential for treatment. Since the range of phenomena to be differentiated is wide, I will limit my comments to two possibilities for inquiry. Are anxiety manifestations an expression of a way to get things done by arousing others, or are they the consequence of a personality dilemma? Patients who seem helpless and very anxious, imploring yet passive and who have a long history of psychiatric therapy, pastoral counseling or casework therapy, face us with the question whether running for helpful guidance and arousing missionary spirits in others

has become part of their coping pattern. Profound inadequacies may exist in many areas, but these patients may be expert at the "dumping problems in other people's laps" manner of behavior. They are just as good at this as someone else may be good at running a store. The therapist must be keenly aware of this, for the patient will be cooperative in investigating the past and the distressing present and yet misuse therapy as part of the established way of conducting his business of living. Beneath this tactic of helplessness we must bring into direct focus the patient's thoughts, desires and feelings and help him organize these into a preferable plan. Bringing others into action tends to obscure what one thinks or what ought to be done.

Most of the time anxiety is the consequence of inner personality dilemmas in which the patient is confronted with alternative courses of action, neither of them compatible with his way of existing. For the sake of simplification I will invent an example.

A boy who had a good record in elementary school falls behind in junior high school and develops severe attacks of anxiety. In elementary school he had developed the pleasing notion that he was so bright that he had no need to study, while his fellow students could match his level of performance only by hard work. Now school requirements had changed, however, and he finds himself confronted with the choice of failing or the shame of making an effort.

It is important to remember that it is the conflict rather than the scholastic delinquency that caused the anxiety. Another boy may also fail but not be troubled by his failure as he has decided that "school is not important" or that "learning is not for him." More precisely, it is the fact that he is trapped by the conflict that causes the anxiety. The first boy's self-image was that of effortless, superior brightness; his expectation was that he would come through with flying colors. He found himself in difficulties when his performance did not match his expectations. The second boy's self-image was one of "he who fails," and his expectations and his performance were in accord with his image. This boy

might be disquieted by unexpected success, a phenomenon frequently encountered in adult therapy.

Patients will say, and therapists often think, that anxiety disrupts functioning. However, in stressing conflicts as a source of anxiety we are reversing the proposition. Anxiety appears because we cannot function because intentions are jammed. A clinical observation bears this out. We see patients who insist that they are afraid to telephone, make business contacts, learn how to drive or to speak to an audience. They strenuously avoid these activities and have avoided them for years. The mere contemplation of such engagements causes anxiety. But one day something happens that either leaves them no choice or that tips the balance of motivation in favor of the activity, and the person does what he dreaded doing without a flicker of discomfort. The relief is great and the improvement may last. The only change in the patient is that he acts rather than agitates about the not doing.

The implications for therapy are modest yet significant. Symptoms may be an expression of a more pervasive difficulty in living, which has no easy answer. But dramatic favorable and lasting changes in patients warn us to retain some therapeutic optimism. Conflicts and trappedness in dead-end living experiences are part of human existence. Resourcefulness depends on many factors; rigidity of personality characteristics is only one. Change is not only related to the resolution of old patterns and reactions but also to seeing new possibilities, new contexts and new ways of perceiving our situations and relationships. As therapists we are apt to overestimate the "ruttedness" of behavior. We do not sufficiently entertain the possibility that the person may be in a rut because he literally does not see acceptable alternatives. When he does, he may surprise us with the ease with which he leaves the rut behind.

The anxiety of a person who feels caught in a jam looks the same no matter what the source of the difficulty. Neither the intensity of the anxiety nor its duration are of prognostic significance. Obtaining a good history of the person's personality

development leads to a historic understanding, but it does not necessarily give us an estimate of the potential for change. Our theories have viewed character traits or patterns of existence too much in the light of defense mechanisms and from the vantage point of the ideal norm. The implications were that we would have the necessary flexibility of character, the capacity to learn and cope with no matter what, if neurotic defenses did not interfere. Anthropology and sociology have taught us a more realistic view. We normally grow into existing patterns of our culture and subculture. We adapt to a select way of

existence which may well be at odds with circumstances encountered at a later point in life.

The challenge of our time demands a much greater capacity for tolerating change than ever before. We need to keep up with the times and develop a willingness to relearn. Our theories have favored the idea that the personality is basically set at five years of age. I believe we need to reorient ourselves and learn more about man's potentials for change. A re-evaluation of our too one-sided concepts of anxiety may contribute toward greater differentiated therapeutic effectiveness.