PSYCHOANALYSIS AND RELATED METHODS

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ANXIETY AND RELATED DISORDERS

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In all psychoanalytic psychotherapies, far from being an isolated target of diagnostic concern and treatment, or simply a troubling symptom to be controlled, anxiety functions as an invaluable assistant to patient and therapist in their task of identifying areas for exploration and understanding. Moreover, despite their differences, all psychoanalytic approaches treat the presence of anxiety as an indication of a problem with self-regulation.

While the DSM-III-R defines anxiety in terms of intensity and duration of signs and symptoms, psychoanalytic models assert the centrality of the role anxiety in personality development and psychopathology, but with importantly different emphases. Four of the most widely practiced and published models—classical Freudian, interpersonal, object relations, and self-psychological—will be discussed with regard to the role of anxiety and its treatment in clinical practice. Space limitations necessitate emphasizing some authors and schools of thought over others, but a wide sampling is nevertheless included.

CLASSICAL APPROACHES TO ANXIETY

I will begin with the classical Freudian view, since subsequent psychoanalytic developments treat Freud's work as a point of departure. Starting with the classical approach, it is necessary to present the theory of the unconscious origins and causes of anxiety, because classical psychoanalysis is a depth therapy that does not aim for symptom amelioration directly, but rather aims to address the unconscious determinants of symptoms. In fact, this is true of most psychoanalytic theory and practice, and this point will be developed throughout this chapter. As Beck (Beck & Emery, 1985) stated:

> Anxiety ... is not the pathological process in so-called anxiety disorders any more than pain or fever constitute the pathological process in an injury or an infection. We should not allow nature's mechanism for dramatizing the feeling of anxiety to mislead us into believing that this most salient subjective experience plays the central role in the so-called anxiety disorders, (p. 14)

Thus, anxiety in current psychoanalytic approaches is to be investigated for its underlying dynamic causes, and not directly alleviated per se. In practice, then, anxiety becomes the *starting point* for a psychoanalytic inquiry. That is why, for example, in the initial interview we typically look for the trigger to the present disturbance or, as it is usually called, the precipitating event. Without this information concerning the point around which anxiety surfaced, the therapist may often feel dislocated, at a loss to know how to

proceed. Freud himself treated anxiety as only a starting point for treatment. To Freud, anxiety was both a striking and a common feature of everyday human life, familiar to normal and neurotic individuals alike. More importantly, anxiety in psychoanalysis became the central vantage point for arriving at a full and deep understanding of mental life. For these reasons, anxiety was one of the first problems for which Freud suggested an explanation.

Toxic Theory of Anxiety and Clinical Practice

Even though the experience of anxiety is common to all, the unrealistic and irrational nature of anxiety set it apart from fear. After describing anxiety's morbid manifestations, Freud turned to the problem of alleviating anxiety in neurotic individuals. In his earliest formulations, Freud (1895/1963) asserted that neurotic anxiety, seen most typically in its phobic or free floating forms, resulted from unemployed libido. Anxiety came from unexpressed sexual urges.[1] This principle constitutes what has been termed Freud's *primary* (Fischer, 1970) or *toxic theory* of the causes of anxiety. The theory derives its name from the so-called toxic effects of sexual urges which, when unable to find discharge or suitable gratification, are instead transformed into the noxious experience of anxiety which in turn disrupts the functioning of the psychic system. The cause of ungratified sexual urges were thought to be many, including trauma, repression, and unhealthy sexual

practices such as coitus interruptus or abstinence.

In the case of trauma, such as sexual seduction in childhood, the relatively immature ego of the child is unable to master the sudden and immense activation of conscious and unconscious urges and associated fantasies that typically result. This inability, combined with societal injunctions against disclosing sexual trauma and its sequelae, leaves the child in a state of excessively high excitation without the ability or opportunities necessary to relieve it. The traumatic nature of childhood experiences inhere in the helplessness of the child to relieve in any appreciable way or mitigate against their effects.

Repression, on the other hand, contributed to the build up of anxiety in a different way. Freud (1917/1963) stated, "Repression corresponds to an attempt at flight by the ego from libido which is felt as a danger" (p. 410). In repression, a defense of the ego against threatening urges, the ideational component of the urge (the wish) is banished to the unconscious. Since, however, the affective (or, in Freud's biological terms, energic) component of the sexual urge cannot be similarly done away with, it is transformed into anxiety.

The idea Freud had developed, and which formed the theoretical basis for his toxic theory of anxiety, is that sexual energies could never be quieted.

If denied expression over a prolonged period of time, sexual urges would accumulate until they eventually created a toxic psychophysiological environment, the result of inhibitory practices that blocked the psychic system from its usual method (discharge) for regulating internal tensions and excitations. The inner toxic environment was experienced subjectively as anxiety. Freud's theory of psychopathology was thus, at this early stage, heavily influenced by this biological model of the human psyche. The idea of mental treatment for the neuroses had not yet gained acceptance. Treatments for anxiety states at this stage in Freud's clinical practice were most typically electrotherapy, drugs, baths, massage, suggestion, and hypnosis. Hypnosis captured Freud's attention, and he used it extensively to suggest symptom abatement to his patients and to bring about *abreaction,* an opening up of blocked pathways allowing the free flow of previously dammed up psychic tensions.

Abreaction is viewed today as an elementary form of treatment for anxiety. Aspects of this approach constitute the essential starting point for therapy of some anxiety disorders such as those resulting from posttraumatic stress disorder (PTSD) of war or combat experience, sexual or physical abuse, and other stressors (e.g., sudden loss of a loved one due to divorce or illness, and personal illness which exceeds the individual's usual capacity to handle problems of everyday life). To illustrate how abreaction in clinical practice works, consider the case of PTSD. Hendin and Haas (1988) explain how

repetitive dreams of combat trauma constitute an attempt to be prepared after the original traumatic events. Repetition in dream experience may dissipate traumatic anxiety because, unlike the original trauma where the individual was unprepared and thus overwhelmed by horror and fright, this time the individual exerts a degree of control over the experience by recreating it himself, under conditions of safety. Psychotherapy of the PTSD patient usually entails vivid re-experiencing of trauma in waking life, so that as in dreams, previously blocked affect is released, undoing the anxiogenic effects of the original trauma. In therapy, the ego is assisted so that the overwhelming conditions (such as helplessness) which prevailed at the time of the original trauma are mitigated. In the psychoanalytic treatment of adult survivors of childhood sexual abuse, re-experiencing the hated and feared intensity of the original trauma either through abreaction or in the transference relationship, is also deemed necessary. Re-experiencing trauma in one form or another is a precondition for eventual healing of the various fractures and dissociations that evolved to deal with the original traumatic events (Davies & Frawley, 1992; Shengold, 1989).

The technique of free association also borrows from toxic theory. In free association, a patient is instructed to say everything that comes to mind no matter how seemingly trivial. This is based on the idea that the repression of wishes that threaten the ego has been at work and needs to be countermanded. The permissiveness of the psychoanalytic treatment

situation is meant to correct the repressive attitudes and practices of the ego, and instead to allow the unblocked flow of ideas previously barred from consciousness.

As discussed, the toxic theory of anxiety informs psychoanalytic methods for working with patients suffering anxiety from repressed traumatic experience in adult life and earlier in childhood. In addition, aspects of toxic theory lie behind treatment approaches to inhibitions in sex and at work. In general, it could be said that any time a clinician helps an individual to find appropriate expression of previously inhibited conscious and unconscious fantasies and associated urges, that clinician is employing toxic theory to allow the patient a more fully employed libido and its resultant, lessened anxiety. For Freud, full employment of libido in love and work was the best insurance against the occurrence of severe anxiety (Freud, 1926/1963).

Signal Theory of Anxiety and Clinical Practice

In his later work, Freud (1926/1963) developed what has come to be called the *signal theory of anxiety*. Put simply, if in the toxic theory "anxiety is the consequence of repression," in signal theory the direction of causality is reversed and "repression is the consequence of anxiety" (Eagle & Wolitzky, 1988, p. 122).[2] Freud (1926/1963) theorized that the ego was capable of

manifesting a small but noticeable amount of anxiety which was not primarily reflective of pathology but rather which functioned to warn or signal the individual that a danger situation was imminent. As mentioned earlier, for Freud a danger situation was traumatic in that it threatened an individual with helplessness in the face of strongly activated libidinal urges. These urges were dangerous both because they exceeded the ego's capacity for expression and because they placed the individual in a conflictual situation. The conflict was typically one where an individual, because of past experience, feared abandonment, loss of love, castration, or guilt as a result of acting on certain urges. Thus, whereas toxic anxiety ensues from negative experiences already suffered, signal anxiety serves to warn the individual about negative experience anticipated in the future; and whereas toxic anxiety originated somewhere in the body (i.e., the seminal vesicles or the subcortex), signal anxiety is a product of the mind, originating in the ego.

The development of the signal theory of anxiety came at the same time that Freud expanded the role of the ego in his structural theory of the mind. Whereas toxic theory was concerned with the fate of libidinal urges, signal theory focused instead on the reasons and methods by which the ego kept certain wishes and urges from awareness. The signal function of the ego explained the deployment of ego defense mechanisms in the following way. With the onset of signal anxiety, the ego would employ a variety of defenses, principally repression, which would insure that the forbidden and feared

wish remained out of awareness with no possibility of becoming enacted. In this way, anxiety resulting from anticipated danger situations was usually controlled. The signal theory opened the door to the analysis of anxiety, and not merely to the unblocking of its negative effects via abreaction. Now anxiety could be viewed as an adaptive affect, not merely one that reflected a pathological process. Psychoanalysis could now view anxiety as a guide-post, an alarm concerning an impending danger situation such as separation from mother, loss of body contents and bodily harm, or death itself. Following the eruption of anxiety back through the train of free associations to its incipient moment became a method of uncovering unconscious conflict. For example, if in the course of a psychotherapy session, a patient became quiet, conciliatory, or vague, it could be viewed as a defensive response to an anticipated danger situation. Seen this way, the cause of anxiety and the various ways in which it is defended against in the therapeutic arena (i.e., defense and resistance), takes center stage, promising to point the way to unconscious terrain.

The promotion of insight through interpretation of unconscious conflicts and unconscious origins of anxiety is the primary goal and method, respectively, of psychoanalysis. An anxious response of a patient, for example, may, upon inquiry, turn out to be based on anticipated reprisals from significant people in the environment. Take the case of a young man who is prevented by anxiety from asking his boss for a raise. At suitable opportunities, he stammers or becomes vague. Signal anxiety is at work,

prompting defensive avoidance of the danger situation. But just what is the danger. This young man may unconsciously expect that his request will be viewed as a wish to challenge, to engage in a competition with his boss, and as a result he may fear disapproval or loss of his job as a punishment. Interpretation of the unconscious source of his anxiety and his unrealistically harsh superego might help him manage his wish for a raise both by distinguishing it from urges rooted in the vagaries of father-son competitiveness, and by focusing on realistic tactics and opportunities for securing a higher salary.

This model of conflict between, on the one hand, unconscious urges and prohibitions of the superego and between unconscious urges and the capacity of the ego to construct suitable outlets for these urges, makes fundamental the role of anxiety in psychoanalytic treatment. Anxiety is painful and as such it helps to motivate inquiry into its causes. In a sense, anxiety is the play maker, the force that instigates the therapeutic work.

Ironically, in the psychoanalytic method, the absence of anxiety is maladaptive because it does not serve the clinical process, and it can suggest the presence of a defeatist attitude or large scale withdrawal. Schacht, Henry, and Strupp (1988) point out that it may be necessary in some instances to actually stimulate anxiety in psychoanalytic patients to motivate and facilitate the inquiry in unconscious conflicts. A clinical vignette highlights this issue.

> A 14-year-old girl presented for treatment at a psychoanalytic treatment center saying her mother thought it was a good idea for her to talk to someone. Following this opening, she added that her mother had difficulty with her, and that in talking she hoped to learn something about herself.

In spite of the girl's reasonableness and apparent willingness to enter treatment, she had no emotionally compelling answer to the question about why treatment was being sought now. She had recently participated in two quasi-treatment experiences at her school, but represented these more as pastimes or educational modules than a needed remedy to pressing personal difficulties. The therapist confronted the blandness of the girl's presentation and uncovered a pattern of giving up in the guise of passive conformance to external demands. She feared her own independent desires would be expressed in the form of rebellious hostility, and be received with counter hostility by her mother.

Thus, classical psychoanalytic methods emphasize not only the importance of reducing anxiety of traumatic proportions through expressive release, but also the utility of anxiety insofar as it may help shed light on an individual's struggle with particular unconscious urges. Psychoanalysis views anxiety as a basic condition of human nature. We have primitive and animalistic urges that must be held in check for the sake of preserving the social order. Although anxiety may be inevitable, a sine qua non of existence, its causes can be discerned and our ability to alleviate it is increased. The essence of psychoanalysis as a therapy is its use of the patient's attempt to

recreate or reinstate a situation in the analytic relationship which is similar to that in which anxiety used to occur. With the aid of insight and reason, the patient and analyst try to find new solutions that promise an improvement over the old. This contribution and lasting legacy of classical psychoanalysis is basic to all subsequent approaches.

INTERPERSONAL APPROACHES TO TREATMENT OF ANXIETY

Freud's work on the signal theory of anxiety was published late in his career. Perhaps as a result, signal theory never fully supplanted toxic theory. It functioned as an add-on rather than a basic floor plan. A fuller understanding and appreciation for the centrality of anxiety in mental functioning was thus turned over to Freud's followers, the interpersonalists.

Among them, Harry Stack Sullivan (1953, 1956) is generally viewed as the earliest theoretician and clinician to have offered a collection of relatively complete seminal works. Although not as vast or comprehensive as Freud's works, Sullivan's do nevertheless provide a stimulating alternative to the classical view of anxiety. In addition the writings of Horney (1937, 1950), Fromm-Reichman (1950, 1955), and more recently Levenson (1983, 1987, 1991) and Greenberg and Mitchell (1983) offer varied emphases and additions to Sullivan's. This section will be limited by space to Sullivan. The reader can consult the works of other interpersonalists, starting with

Greenberg and Mitchell (1983) who locate Sullivan and others along a spectrum of what they term *relational theorists*.

The role of anxiety in interpersonal psychoanalysis is at least as important as it is in the classical approach. Sullivan's objective in clinical work was to trace patterns of interpersonal processes that unfolded throughout the developmental stages. In doing so, there were two fundamental concerns to keep in mind: (1) an individual's pursuit of satisfaction of bodily needs, and (2) pursuit of security concerning avoidance of anxiety. Unfortunately, the two aims sometimes collided, creating conflict.

A logical positivist, Sullivan emphasized the importance of what could be directly observed, meaning what the patient said about his relationships with others and what he did in his relationship with the analyst. Sullivan believed that emotional difficulties resulted from poorly observed and, hence, poorly understood experience. Sullivan (1956) felt that no one had severe difficulties in living if he had a very good idea of what was happening to him. Self-awareness and social comprehension were necessary in order to successfully integrate with other people and get on with satisfaction of basic needs.

Interfering with self-awareness and social comprehension was what Sullivan called "selective inattention," scrupulous avoidance of vital aspect of

social interactions. The cause of selective inattention was theorized to be anxiety. There are different degrees of being anxious, but Sullivan spoke mainly of two points in the continuum. One which concerned him very little was mild anxiety, an everyday occurrence for most people. The other which occupied a significant degree of Sullivan's theoretical concern, was sudden, severe, disruptive anxiety that is akin to terror or dread and that occurs for the most part during infancy and in severe pathological states. The individual who has experienced severe anxiety is anxious primarily about being anxious per se, and not primarily about castration or guilt as in classical theory. Sullivan believed that all of us, but pathological individuals in particular, spend considerable amounts of time in our own lives reducing anxiety we already have and in avoiding more of the same.

In Sullivan's theory, anxiety originates not from internally experienced excitation or undischarged libido, but rather from the vagaries of mother-infant relatedness. Because of a strong, innate, empathic link between them, mother and child communicate unpleasurable states of anxiety and pleasurable states of satisfaction back and forth between them. Good feelings in the mother allow her to maintain her attentiveness and positive attitude toward her child and simultaneously afford the child a sense of emotional security or well-being. Anxiety in the mother breaks her attunement to her child, but more importantly, her anxiety is immediately and directly transmitted to the child in the form of a disruptive experience. If the anxiety is

strong enough, dread and intense insecurity ensue. From this, Sullivan pointed out, the child learns about the same as he would from a sharp blow to the head. What actually occurs is that in the interest of maintaining security, the child learns, starting in infancy, to avoid or inattend anything that might make the mothering one anxious. For his own sake, the child learns to identify anxiety states in himself and significant others, to direct behavior, and to conceptualize himself and others as bad (arousing anxiety) or good (not arousing anxiety) in accordance with the overarching goal of minimizing anxiety and preserving interpersonal security.

The interactive strategies or, as Sullivan calls them, "security operations," that an individual evolves to avoid experiencing anxiety and to preserve security is known as the self-system. The self-system is comprised of personifications called the "good me," "the bad me," and the "not me." Not surprisingly, these personifications result from reflected appraisals from significant others and are organized according to the individual's degree of success or failure in minimizing anxiety in others.

The "not me" refers to dissociated aspects of experience that would bring with them overwhelmingly intense anxiety. The individual is normally able to keep "not me" experiences out of awareness, exceptions including dreams and psychotic states. The "good me" experiences are associated with a reduction in anxiety in the self and in the mother, and thereby promote

integration and security. “Bad me” experiences increase anxiety and are associated with parental disapproval or “forbidding gestures,” as Sullivan called them, and a reduction in the sense of personal security.

Thus, anxiety in the interpersonal model is caused in childhood by the mothering one, and not by internal states of unrelieved tension. Defenses are not against awareness of unconscious sources of anxiety, but against causing anxiety in other persons. The self system is indispensable as an organizer of experience and as a regulator of the dangers of anxiety. As Eagle and Wolitzky (1988) point out, the self system functions not unlike signal anxiety in that it can warn the individual of circumstances that could result in anxiety in the individual or in a significant other.

To this point in our discussion of anxiety in interpersonal theory, there has been no explicit depiction of the self system’s regulation of anxiety as pathological in any way. In fact, the self system is necessary for social relations. In the process, however, of serving the individual’s need for emotional security, the efficiency of the self system often becomes a limitation. Security operations become automatic and entrenched because by their nature they restrict awareness through limiting the free flow of attention. New information that might allow an individual some understanding of, for example, the circumstances governing his experience of anxiety or his expectation of causing anxiety in others is never attended. To

attend to such information might leave an individual more vulnerable to the very anxiety he is trying to ward off. To illustrate, consider the following:

> A child's mother is made anxious every time she approaches her for intimacy and closeness. The mother conveys her anxiety in the form of tightened facial expressions, physical distancing, and remarks about her daughter's infantilism. The child learns to deny her need for closeness around her mother and anyone else in a position to offer it (e.g., teachers, nurses, counselors, lovers). To facilitate her denial of her need for closeness, she assumes an aloof and uncaring demeanor, and so converts to coldness anyone's offer of closeness.

This situation often results in a schizoid adaptation in which an individual repeatedly eschews warmth in interpersonal settings, saving herself anticipated anxiety and coldness from others. In the process, such an individual reflexively and repeatedly fails to attain a degree of intimacy and closeness necessary to feel satisfaction with another person. Because of the noxious effects of anxiety, it must be avoided at almost all costs. The good me functions at a considerable emotional cost. Sullivan (1953, 1956) fashioned therapeutic techniques that followed from his understanding of how and why the self system evolved in the first place. The techniques emphasized the importance of the therapist establishing and maintaining a climate of security in the therapy sessions, so that patients might be afforded freedom from their habitual security operations. If interpersonal growth is to occur, patients will need to integrate new information about themselves and others, and this learning cannot occur in the presence of heightened interpersonal anxiety or vigilant security operations that limit awareness about oneself and others.

Perhaps most central to interpersonal analytic techniques is the concept of the detailed inquiry (Sullivan, 1953). It is a form of psychoanalytic inquiry that involves pursuing data, inquiring meticulously into the details and events of the patient's present and past experience in an effort to widen the scope of awareness. This therapeutic strategy revolves around understanding the patient's experience and how he has obscured it. The data pursued are not those concerning infantile urges, but those that concern the dual task of maintaining relationships while avoiding anxiety that could jeopardize security. In interpersonal analysis, the therapist attempts to gradually dislodge the patient from the comfort of his entrenched security operations by asking often discomfiting questions and making observations that bring the patient's awareness to previously inattended data. Many patients habitually talk with such coherence, consistency, and closure that decentering them via questions is not easily accomplished. Consider the following example:

> A young married man reports fear over having an anxiety attack and losing control of his feelings. He recently had an anxiety attack at a public arena and had to be escorted home by his wife. He also has irritable bowel syndrome with bouts of diarrhea and is afraid to take some trips away from home. He described intense worry over the preceding weekend about a planned trip to a nearby suburb. When asked where he was going and who he was going to see, he snapped back, "I don't see what that's got to do with anything!"

A moment of anxiety had clearly been reached, evidenced by his forceful

rebuke. As the inquiry focused on details he previously inattended, anxiety erupted forcefully, clouding the emerging focus of awareness. Later discussions revealed he was planning to visit his wife's family and was ashamed of the extent to which he feels pampered, adored, and even infantalized by them, and he expected the analyst to belittle him for his indulgence.

In this instance as in most, detailed inquiry entails a cost, the *creation* of a certain amount of anxiety, but it also promises the benefit of increased interpersonal awareness and competence. Remember that Sullivan believed the patient was socially maladapted because he did not know what was happening to him and around him. The individual needed to increase awareness of himself and others in order to respond adequately to them. Recall the example of the isolated woman who sees only rejection, only social cues that conform to the aims of her self system. She suffers from not seeing openness and warmth in others where it exists, and from engendering aloofness in others. She does not see her own aloofness because this would expose her anew to the possibility and attendant anxieties that come into play in human intimacy. As Levenson (1987) points out, the purpose of the detailed inquiry is the search for the truth inherent in appearances, not the search for truth behind or hidden by appearances. The classical psychoanalytic model proceeds on the assumption that the truth is being disguised by the ego because it is threatening in some way, whereas

interpersonalists assume truth is there all along, if only an individual can be free from anxiety and notice it.

Sullivan was not very interested in transference, because it was not useful to him. Freudians place great stock in the patient's re-experiencing unconscious conflicts in the analytic relationship, as a means for studying conditions under which anxiety first emerged. The interpersonalists view transference as a sign of excessive interpersonal anxiety and a potential mire. Sullivan wanted to keep anxiety to a minimum in the analytic relationship to allow for more accurate perception of self and others.

OBJECT RELATION APPROACHES

While in this country, Sullivan was writing and teaching the importance of anxiety experienced in early mother-child interactions and in later peer relations, object relations theorists in England such as Fairbairn (1952) and Guntrip (1968) were developing their own ideas about early experience and personality development.. Object relations theory rejects the central classical Freudian idea about libido. These theorists posited an entirely different libido, one that was foremost object seeking, and not pleasure seeking as was Freud's. This basic shift in theoretical orientation lead to an emphasis on the need for attachment per se, and a corresponding de-emphasis on the need to gratify and regulate sexual and aggressive urges. If, in classical theory, the

object is a means to the goal of instinctual gratification, then in object relations theory the instinctual urge is a means to the goal of establishing and maintaining a relationship with another person. Urges are seen as nature's way of assisting people to find others and form lasting attachments.

In discussing the nature of anxiety as proposed by object relations theorists, it is important to keep in mind their view that the earliest experiences of the human infant are characterized by complete dependency. As Winnicott (1960) said, "There is no such thing as an infant, only an infant and its mother" (p. 39). The infant's method of relating to others is through primary identification. Thus, without the other, the infant has no self-experience, no feeling of substance, continuity, or durability. Loss of the object is tantamount to loss of the self. This, then, is the basic anxiety in object relations theory, the experienced threat of loss of the primary object and subsequent loss of the self.[3] Fairbairn felt that in an ideal society, children should be allowed greater periods of dependence than is customary, and that if permitted to outgrow their dependence according to their own timetable, they would not develop pathological defenses against the feared loss of dependency. Conflicts arise between the desire to maintain infantile dependence and the desire to mature and attain a less extreme and more differentiated form of dependence. Evidently, Fairbairn believed in the idea of mature dependence, allowing that throughout life one would need to maintain some dependent relationships, and that psychological health could

be measured by an individual's success in this area throughout the life cycle.

Having once suffered the anxiety of a premature loss of infantile dependence, the individual is motivated to organize certain defensive positions against suffering its reoccurrence. The basic defense according to Fairbairn and Guntrip is the schizoid condition, wherein part of the personality becomes organized around a retreat from relationships with others and becomes attached to internal objects instead. Internal objects are shut off from the outside world and as such offer no opportunities for personality growth or change. What they do offer, however, is protection from potentially depriving or frustrating real objects. This trade off is what is referred to as "the schizoid compromise." The schizoid condition also offers protection for external objects that may come into a person's life. Because of his self-isolation, the schizoid individual need not fear overwhelming others with the intensity of his needs or hurting others with anger over frustration of these needs. Unconscious attachment to internal objects is a source of stability in personality organization for everyone. The problem for schizoid people is that their anxiety over both object loss and over destroying the object out of intense need or anger is so great, that they cling relatively exclusively to internal objects and afford themselves little or no chance for involvement with new external objects.

Schizoid individuals use the analytic setting and the analyst to reenact

early experience by relating to the analyst as if he or she were a remnant of early unsatisfying experiences with caregivers. If this continues unchecked, the present becomes a replay of the past and the future is predetermined. Life is static, still, empty, lacking vitality. Ogden (1989) likened the schizoid's experience to that of an infant suffering merycism, where the same food is swallowed, regurgitated, and reswallowed again and again. The food is thus depleted of all nutritive value, yet it fills the infant's mouth and stomach.

The reason the schizoid compromise is maintained takes us back to the problem of anxiety. There are two feared resultants to resolving the schizoid's pathological adaptation to object relating. They both harken back to the issue of dependency. The schizoid individual dreads new experience that may be conferred by external objects because it threatens to undo the stable, albeit unfulfilling, attachments to internal objects. This threat brings dependency upon an unknown, untested, untried external object (the analyst in the treatment setting). The other fear is that the schizoid's love is destructive, owning to the object's frailty or the intensity of the individual's needs. If these fears are confirmed, the schizoid individual again is faced with an intolerable outcome—aloneness and objectlessness.

Consider the following example:

> A 27-year-old single woman came for treatment reporting difficulty getting over her unreliable former boyfriend. Her father was a cocaine addict whose involvement with her was intense but sporadic. She has been

> counseled by her family to be sensible and to forget the boyfriend, to try and find a better, more reliable man the next time. She complains that this sort of advice, although well intended, goes only to her head and not to her heart, and this is a schism she actively maintains. For example, to the analyst's suggestions that they work on bridging her two modes of experiencing, she rejoins that she's been told that before and it does not help the feeling in her heart which she cannot forsake.

She is attached to an exciting but abandoning internal object derived from frustrating but powerfully effecting interactions with her charismatic but unreliable father. Her actual experience with her boyfriend reinforced her attachment to an intense internal object. She will hear none of her analyst's appeals to her intellect because she experiences these words as an effort to lure her away from what she calls "her heart," a shorthand metaphor for her compelling internal object world. To this unconscious domain the patient stubbornly and tenaciously clings despite conscious and visible suffering of unfulfilled needs for intimate relations.

In the clinical arena, the analyst offers himself as a new object for identification, thereby reactivating the schizoid patient's primary anxieties. The analyst's unwillingness to conform to the patient's projections (i.e., insistence or preconception of how relationships are structured) confronts the patient with the problem of new experience with a relatively unknown external object. In an effort to ward off the impact of new experience, the patient may display contempt and haughtiness with or without withdrawal. Interpretations help mitigate the anxiety of a new relationship by offering a

commentary or a guidebook, so to speak, for new territory. Unlike classical analysts who stress the value of timely interpretations, object relations therapists emphasize the psychoanalytic relationship in and of itself as a vehicle of cure, insofar as it offers the patient new experience. The relationship as the locus of developmental and therapeutic personality growth is key. Interpretations of unconscious fantasies may help the patient understand the nature of basic anxieties over leaving the familial structure of the internal object world, but an attachment to the analyst as a new object, different from internal objects, is indispensable in helping the patient experience the potential for new, less absolute, more differentiated forms of dependency.

SELF PSYCHOLOGICAL APPROACHES

Heinz Kohut's (1971, 1977, 1984) theories of the nature and treatment of anxiety depart radically from Freudian theory, and hold much in common with object relations. For Kohut, the central anxiety is over experiences of disintegration or what he termed loss of the cohesive self. In its extreme, this experience is a loss of a sense of humanness, a feeling of being totally bereft of needed emotional connectedness with others. Unlike classical theory, what is feared is not unmanageable libido, but the threatened breakup of the self.

The cohesive self ordinarily obtains from early experiences of what

Kohut called mirroring and idealization. Accordingly, individuals require in the course of normal development, extended periods during which nascent feelings of grandiosity are mirrored or supportively reflected by the parents. In addition, individuals require opportunities to idealize caregivers' traits of, for example, power, strength, or mastery. In everyday terms, the grandiose self of the child may be mirrored in the mother's proud smile; the idealized traits of the parent depicted in the image of the father's repair of a broken toy. Owing usually to inadequate empathy on the part of the parents (but also resulting from constitutional factors of the child), insufficient or unreliable provision of vital emotional experiences or mirroring and idealization can leave an individual with an enfeebled self vulnerable to anxiety over disintegration.

To illustrate this point, consider the different emphases classical and self-psychological approaches place on oedipal anxieties.

Kohut believed that the experience of castration anxiety, normally present in the oedipal phase, is not necessarily traumatic for the child. Given a sufficient degree of empathic involvement from the parents, a child could accrue feelings of pride and vigor from successful mastery of oedipal rivalry. The parents could admire the child for the adult he or she will become, and actively assist him or her in appropriate steps toward that goal. If, however, the parents are deficient in offering empathy, the child may remain fearful

and angry at the parent, beyond a phase-appropriate time period. Left alone with these feelings, anxiety over disintegration will mount and defenses such as anger and withdrawal are erected to manage it.

The relationship of the individual to an empathically mirroring or idealizable other was termed a self-selfobject relationship (Kohut, 1977). By use of this terminology, Kohut aimed to develop a psychology emphasizing an individual's need for different kinds of empathic relationships at various developmental stages. So, for example, one and two year olds may need selfobjects for mirroring, just as adults may need the self-selfobject relationship of twinship (Kohut, 1977) to provide a sense of cohesion through connectedness to a like or similar other. Just as Fairbairn and other object relations clinicians believed forms of dependency should be accommodated in adult life, so did Kohut believe that the need for selfobjects persisted throughout the life cycle, and that mental health depended on availability and freedom to utilize a wide range of these relationships.

The need for selfobjects resolves directly around the problem of anxiety over the lack of a cohesive self. The more available empathic objects are early in life, the more cohesive the self and the more able the individual is to manage anxiety. Self-psychological treatment methods focus on provision of needed empathic relationships with the therapist. Should a patient, for example, require mirroring to support an activated but weak grandiose self-

structure, the therapist will provide it. Since any therapists's capacity for empathic involvement is by no means absolute, however, breaks in empathy ultimately occur, leaving a patient vulnerable to disintegration experiences of varying degree and kind. These are typically manifested clinically as drops in self-esteem (e.g., shame reactions), feelings of discontinuity (e.g., depersonalization, disorientation), or intense range reactions. The therapist's role at such junctures is to identify his empathic failure, provide understanding to the patient about the anxiety-producing effects of the failure, and in so doing to restore an experience of empathic attunement. In this way, a sense of cohesiveness is restored. Most importantly, two other therapeutic gains are realized. For one, the patient may evolve a sense of himself as relatively durable and strong insofar as he recovers from anxiety over his rage. Providing anxiety is not too extreme, it can be suffered and relieved. This is strengthening and growth promoting for the grandiose self. Secondly, the patient forms an amended view of his therapist as someone who is imperfect but nevertheless available. The selfobject is tarnished, but its shine is restored. Repeated nontraumatic experiences of anxiety over loss of the grandiose self or idealizable others are therapeutic because the patient learns to depend less absolutely on self-objects who are tolerated as less than perfect. Ultimately, the patients learns to find self-objects in his life that take the place of the analyst.

Self-psychology's similarity to object relations is underscored by the

fact that in both treatment methods, the evolving relationship with the therapist is crucial as a method for encountering anxiety and for creating new experience. In both models, relationships are primary, and not secondary to the more primary problem of libidinal regulation. Most centrally for this chapter, both methods see anxiety resulting from the loss of primary or essential objects and subsequent loss of the sense of self. This stands in contrast to the classical method where anxiety stems from conflicts over sexual or aggressive libidinal urges that are forbidden by societal norms.

CONCLUSION

There are large differences in the understanding and treatment applied by different psychoanalytic schools to the problem of anxiety. These differences have been clearly outlined recently by Greenberg and Mitchell (1983) in their distinction between the drive/structure and the relational/ structure models. Classical theory adheres to the former model, while interpersonal, object relations and self-psychology fall under the latter. Regarding treatment, the centrality of the patient's struggle to maintain a relationship to the analyst and to others is obviously given more weight in the relational/structure models.

What all of these treatment approaches hold in common include a view that, as Beck (Beck & Emory, 1985) argued, anxiety is not the pathological

process to be treated per se in anxiety disorders. Instead, it is an indicator of unseen disturbances that must be unearthed. Whether the metapsychology of a particular approach predicates blocked libido, inattended experience, object loss, or loss of self-cohesion as the basis for anxiety, all schools nevertheless view anxiety as a symptom and not as an illness in itself. As a symptom making its appearance in the analytic encounter, it is an invitation to psychoanalytic inquiry and understanding in the context of a containing and reparative relationship.

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Notes

[1] The term *urge* will generally be used in place of the terms instinct or drive. The author believes it conveys Freud's idea of the subjective experience of the pressure of the drive and some of the biological sense of the term instinct, but in more everyday experiential terms. See G. Klien's (1970P) article. "Freud's two theories of sexuality" for an interesting discussion of this problem.

[2] As Eagle and Wolitzky (1988) point out. signal theory did not replace toxic theory, it merely added to it. In most of Freud 's clinical work, he relied on both theories simultaneously.

[3] Although in this presentation primary object loss is viewed as the core anxiety, it is important to keep in mind that experiences of persecution and engulfment by the object are also posited as basic anxieties in object relations theory. These anxieties are ref lected in

defensive organization of the personality just as object loss is.