THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH PATIENTS WITH PHOBIAS

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Psychotherapy with Patients with Phobias

Phobias are familiar phenomena of everyday life as well as manifestations of mental disorders. A phobia is a morbid fear of objects or situations which realistically do not constitute a genuine danger to the person. In a clinical descriptive way, phobia denotes a phenomenon which ordinarily cannot be dealt with in an objective or rational fashion. The morbid fear has become attached to objects or situations and is usually recognized by the phobic person as not being a source of danger. Nevertheless, there is a compulsion to stay away from the imaginary threat. There may even be physiological responses characteristic of facing an actual danger such as tachycardia, rapid breathing, sweating, gastrointestinal symptoms, tremor and so forth. The victim of the phobic reaction is ordinarily aware of the relative harmlessness of the situation. He frequently does not know what he is actually afraid of. Nevertheless he feels compelled to avoid phobia-producing situations. His insight into the inappropriateness of his phobic response does not protect him against acting irrationally.

There is little doubt that many people have been plagued by some irrational fears which they may have concealed from outsiders or rationalized to themselves and others. They may have dealt with their excessive concern either by attempting to cope with it somehow or by permitting themselves to yield to unreason. Conditions of the above-described nature qualify

technically as phobias, but they usually have little clinical significance. On the other hand, some phobias may veil the existence of moderate or even severe psychopathology.

In classical psychoanalytic theory, phobias are grouped with anxiety hysterias. The concept is closely linked to the framework of libido theory, whereby "the libido which has been liberated from the pathogenic material by repression is not converted but set free in the shape of anxiety." It is postulated that the anxiety hysteria develops into a phobia when the effort of psychically binding the released anxiety fails. In phobias the anxiety is cut off from reconversion into libido and cannot be attached to the complexes which were the source of the libido. In other words, all avenues connected with the formation of anxiety are foreclosed by erecting mental barriers in the nature of precautions, inhibitions and restrictions. "It is these defensive structures that appear to us in the form of phobias and that constitute to our eyes the essence of the disease." Freud did not make a definitive statement concerning constitutional versus experiential factors in the formation of phobias. However, he stated that to his way of thinking phobic states were least dependent on a constitutional predisposition and of all the neurotic disorders were most easily acquired at any time of life. Freud also felt that the cure of a phobia could not be accomplished by forceful intervention. He cautioned against depriving the patient of his defenses and leaving him prey to the liberation of his anxiety. At the same time he stressed the necessity of having

the phobic patient face the feared situation rather than avoid exposure to the dreaded situation or object.

The concept and treatment of phobias have undergone some significant modifications since Freud's initial exposition which will be discussed in some detail later on in this text. Generally speaking there has been growing criticism of the mechanistic and nonpsychological hypothesis of the libido theory with its major focus on quantitative, physiochemical factors as a primary basis for human behavior. Instead of viewing human attitudes as being mainly governed by bio-physiological forces, the emphasis has shifted to adaptational disturbances in response to environmental influences. Our major field of interest here is in the complex interplay or transaction between the organism and its total surrounding milieu. The waning of the topographical point of view with its main goal of making the unconscious conscious has contributed to this reorientation by paving the way for interpersonal considerations. There is no longer a need to trace a thought from its origin in the dark recesses of the unconscious to its emergence into conscious awareness. Greater appreciation can now be given to the actual experience of person-to-person encounters. Transference then emerges less as an inherent repetitive compulsion but rather as an open-ended channel for interpersonal experience. In addition, the growing focus on structural aspects has placed the defenses of the ego, or the adaptational factors, in the foreground. Along with this evolution, concepts of ecology and information

theory have gained a foothold in modern psychoanalytic thinking. The ecology principle relates to the interdependence of human as well as environmental transactions. It rejects the concept of a purely intrapsychic process and stresses the constant interplay between the inner and outer life of a person without a stable line of distinction between them. Another consideration in classic theory is the fact that energy (libido) is considered to be a decisive factor in regard to a person's actions and activities. The available amount of energy determines the degree of tension which is built up either to initiate activity or to accumulate energy to the point where pressure is created as a result of psychological or external barriers which prevent its release. Thus there is no potential for activity unless energy is stored up. Modern information theory, on the other hand, is much less concerned with quantities of energy. It has been shown that the vital event of exchanging information takes place with a minimal expenditure of energy. The important aspect of our newer concept is the rearrangement of forces within a field which occurs in the process of coding, decoding and transmitting information without major energetic requirements. In other words, many events of major significance involving the organism and the environment are not primarily dependent on the absence or presence of energy. For example, an individual may feel magnetically drawn to another person of the opposite sex. The person may account for his intense emotions and desires with the explanation that he has "fallen in love." It may be possible to demonstrate to

this individual that his state of heightened energy may actually be the result of a malignant rather than a healthy process. The data may indicate that he has found the “perfect partner” to perpetuate his neurosis.

One may be able to document to him that his powerful attraction to the other person is part of a pattern designed to lower his self-esteem, and a thoughtful therapeutic dialogue may shed light on the irrationality of his behavior. The person may now have a chance to correct his attitude on the basis of additional information made available to him. There is no guarantee that he will use the information constructively, but it provides an incentive for a different course of action. The point is that there has been no change in any respect regarding the available energy level. Rather, there has been a transmission of information which enables the person under certain circumstances to rearrange his interpersonal field in a positive manner.

In this chapter, phobias will be discussed mainly as thought disorders which are closely related to the obsessional states. The opinion will be advanced that it seems appropriate to view phobias and obsessions as one clinical entity, contrary to the classic point of view. Phobic and obsessional phenomena will first be discussed independently before concentrating on the common features of both conditions. The metaphoric nature of obsessive-phobic communications will be explored with particular attention to the existence of faulty perception and distortions in communication. Faulty

perception refers predominantly to a pattern of certain recurrent distortions which interfere with an objective evaluation of what the patient thinks of himself in regard to other people—that is, the way he imagines others look at him (the patient's reflected image of himself in the eyes of others). Although perception is, of course, a much larger field, it is this aspect of perception which I believe is most relevant to phobias. In regard to distortions in communication, attempts will be made to show how in obsessive-phobic people important messages were transmitted through a warped, familial network of communication. It is suggested that certain phobic symbolisms can be directly traced to the maladaptation and malfunctioning of the nuclear family unit.

In regard to treatment, the revival of behavior therapy with its methods of desensitization has paved the way for dealing with certain uncomplicated phobic symptoms. However, the treatment of the majority of phobic-obsessional symptoms has not been affected by the behavioral approach. The task of accomplishing durable characterological and perceptual changes is formidable and some suggestions for improving the technique will be made later on. Significant modifications in the treatment approach center on a different understanding of the phobic process as well as on concepts of the nature of anxiety.

CULTURAL FACTORS

It can be said that phobias and depressions are probably among the most widespread psychological manifestations in daily life as well as in the realm of psychopathology. Certain phobias enjoy a high degree of social sanction despite the irrationality that may be involved. Phobic attitudes toward snakes, for example, are so common that they are rarely considered to be phobias as such. Among the more than two hundred phobic patterns, I have not encountered names for children's fear of the dark or phobic reactions to rats, mice, snakes and so forth.

Many cultures and societies tend to foster phobic reactions by imposing exaggerated threats of punishment on basically harmless infractions of the prevailing code. Our training and information are richly interspersed with misconceptions about the alleged danger of certain attitudes, actions and thoughts. It is fairly common, for instance, even among well-educated Europeans to be afraid of ice-cold beverages as health hazards. The cultural phobia of, for example, the supposedly dangerous qualities of "outsiders," "foreigners," "deviants," etcetera, is often a means of exploiting underlying prejudice. Thus, it is not an easy task for a child to know who is friend and who is foe, what is a genuine hazard and what is relatively safe.

Every culture has a host of irrational tabus about non-injurious practices and activities pertaining to eating habits and sexual, social, religious, political, economic and other aspects of life. Traditions are a powerful factor

in governing human behavior and many fears are engendered because there is a clash in the culture between conventional and nontraditional behavioral patterns. An example may be found in the phobic attitude of the present older generation toward all drugs and the reckless anti-phobic attitude of the younger generation in that respect. For instance, marijuana smoking is considered by many elders as being highly dangerous. There is good reason to believe that the degree of the actual danger is frequently exaggerated and not based on the best evidence available today. On the other hand, the younger generation takes it for granted that they are dealing with a perfectly harmless substance without having proof that this has been clearly established. It is this sharp clash between two polar opposites, each irrational in its own right, which in my opinion forms a frequent basis for a culturally prepared foundation for phobias. However, in order to develop the clinical disorder of phobia, we need the additional component of a particular family disturbance as will be discussed in some detail later on.

HISTORICAL REVIEW

Clinical descriptions of phobias and obsessions have been with us for a long time. According to Zilboorg, it was Hippocrates in the fourth century B.C., who first gave an excellent description of what appears to have been a psychoneurosis with phobias. The French psychiatrist, B. A. Morel, is usually credited with the first clinically valid illustration of an obsession (1861).

Kraft-Ebing (1879) made reference to compelling, persistent thoughts *(zwangsvorstellungen)* which could not be eradicated from the mind and whose pondering quality defied reason. Griesinger (1870) included in the term "obsession" a compulsive need to ask questions. Autochthonous ideas were coined by Westphal (1877) to describe obsessional impulses which seem to intrude from the outside as if they had been thrust upon the patient by demonological forces.

Charcot (1885) used the term "onomanomanic" in reference to an obsessional preoccupation with names and words where, in extreme situations, the victim would feel compelled to shout the names or words. Ladame (1890) referred to phobias and algias as part of the obsessional syndrome. Janet (1903) linked obsessions with psycho-asthenia and hypothesized a morbid diminution of psychic energy as a causal factor. This in turn led to a ruminative, obsessive-compulsive tension state with a concomitant disturbance in reality perception. The result was a state of mental anarchy without adequate control over higher functions. According to Janet, the phobic reaction is closely related to hysteria, since both conditions constitute avoidances of feared situations.

Historically speaking, phobias and obsessions were grouped together as one clinical entity until the advent of psychoanalysis. Freud exhibited an early interest in obsessions and phobias in a paper entitled "Physical Mechanisms

and Their Etiology." In this paper, he insisted that a clear distinction be made between phobias and obsessions; that they were separate neuroses. According to Freud, the obsession is actually a thinking disorder with doubt, remorse, anger, ambivalence, etcetera, as the basic associated emotional states. Obsessions are genetically related to the anal-sadistic phase. Freud postulated the principle of displacement in obsessions as a dynamic factor. In true obsessions, the original idea connected to actual painful experiences in the sexual sphere has been displaced. The obsessional person attempts to forget the memory of the primal scene by repressing the disturbing sexual aspects. Focal attention is diverted from the painful area to a peripheral, obsessional preoccupation. Freud added other psychic mechanisms in order to account for obsessional behavior. These were ambivalence, an unresolved conflict of loving and hateful impulses; doubting, an ever-present manifestation of indecision; and isolation, a neutralizing device designed to obscure the affective origin of a thought. Freud uses the term "isolation" when he speaks of the separation of an idea or memory from its affective cathexis.[1] Finally, Freud used the constructs of regression, omnipotence and ellipsis to describe the obsessional people as a way of substituting thinking for acting, as a "compromise formation" between two antagonistic impulses which, when it comes to action, leads to a self-centered, infantile frame of reference. Ellipsis is a distortion by omission. It refers to a thought process which is distorted because a central issue is left out.

In contrast, phobias center exclusively around the emotional state of morbid anxiety. The typical emotional state in phobias occurs only when the person is confronted with the alleged danger. It is not present as long as the seemingly dangerous situation is avoided. We must appreciate here that Freud's initial concept of anxiety was based strictly on a chemical, physiological process. It meant that people with inadequate sexual outlets would build up toxic substances in their system. The cure for this so-called actual neurosis, or as Ferenci named it "physio-neurosis," was exclusively to have a more active and a more satisfactory sexual life.

Later on, Freud expanded the concept of anxiety by making it a predominantly psychological phenomenon. In the later theory, anxiety represents a warning from within when impulses based on wish fulfillment clash with censorship mechanisms. Current psychoanalytic thinking transcends this concept in many areas. It runs the gamut of existential, humanistic, non-pathological anxiety and other considerations. A significantly different point of view is injected by the tenet of anxiety as postulated in interpersonal theory. Anxiety in this frame of reference is not part of the human, constitutional makeup but is acquired by means of exposure early in life to people who suffer from anxiety. Accordingly anxiety is postulated as an experience which is basically alien to the human organism since it has no particular anatomical pathway to deal with it. The consequence is that according to Sullivan, anxiety, once it is imprinted in a person, remains there

as a lifelong experiential ingredient which cannot be removed or minimized.

Eventually Freud settled the problem of phobia with his classic presentation of "Little Hans." He considered the principle of substitution and displacement to be central in the phobic reaction. The boy's ambivalence toward his father is displaced onto the horse, which seemingly becomes the main threat in the boy's life. It is possible for the boy to avoid the horse which obscures his fear of his father as a castrating figure.

It seems to me that Freud unwittingly moved closer to a rapprochement between obsessions and phobias than he realized. In the obsessions it is the primal scene which is displaced, while in the phobia there is a displacement which consists of a shift of object from the father to the horse. The fact remains that both the victim of the phobia as well as of the obsession is unaware of the underlying fear and that he is warding off the confrontation with a conflict. In the obsession he supposedly wants to forget a painful sexual memory, while in the phobia he is afraid of the consequences of his unconscious wishes. There is little doubt that the causal assumptions in both instances are unproven and highly speculative.[2]

To my way of thinking there is no valid theoretical or clinical justification for splitting the obsessive-phobic complex into two separate entities. For one thing we have ample evidence of a common thought disorder

in both conditions. Obsessional and phobic patients alike suffer from a mild delusional distortion in spite of the frequently glib rationalization of the phobic person. Neither obsessional nor phobic patients have the capacity to perceive themselves in relation to other people with any measure of accuracy. Both rely on a coded, metaphoric language which is similar to dreams. It defies logic to believe that the phobic patient has a pinpoint anxiety which he can manipulate by avoiding the anxiety-producing situation and that except for this particular foible he is emotionally intact.

I prefer to view both phenomena as one nosological category. Both obsessions and phobias are states of preoccupation whereby the focus of attention is diverted from the relevant aspects of a particular interpersonal situation. For instance, I have observed in patients with hypochondriasis a distinct tendency to combine both obsessive and phobic phenomena. The hypochondriacal person is obsessed with thought of ill health and is phobic about the malignant nature of his alleged illness. Similar considerations apply to some paranoid and to many algolagnic conditions.[3]

We can understand how Freud's genius went astray in separating obsessions and phobias. Freud was committed to a primarily internal conceptualization of neurotic conflict. He was convinced that the basic threat in phobias came from instinctual demands as illustrated in the following quotation: "The ego behaves as if the danger of an outbreak of anxiety

threatened it not from the direction of the instinct but from the direction of perception." The thesis of this chapter reverses this concept by placing the perceptual disturbance in the foreground of both obsessional and phobic conditions.

POST-FREUDIAN DEVELOPMENT

It is remarkable that Freud's ingenious theory of phobia has remained virtually unchallenged for sixty years. Furthermore, little attention has been given to the work of others who have made significant observations concerning the nature of phobias. In this connection, certain clinical studies of Sullivan's merit consideration.

Sullivan did not consider phobias a specific clinical entity nor an isolated manifestation of psychopathology. Rather, he grouped phobias with obsessive phenomena and with compulsive doubting. He viewed severe phobias as an enduring warp of the personality which he traced to a very early developmental period. It was his belief that the phobic pattern had its origin at a time when the infant's spontaneous self-exploration was disrupted by the mother's overwhelming anxiety. The infant's needs were regarded by Sullivan as being insufficiently gratified as a result of

personal and cultural misperceptions of the mother. That is, the mother was seen as being extremely vulnerable as to what she perceived to be

society's expectations of her, thus having an exaggerated feeling of social responsibility. Sullivan conceives of two elementary human requirements which he calls needs and satisfactions respectively. The former are related to the basic biological requirements of the organism while the latter pertain to sociocultural necessities. Ordinarily the infant's needs evoke tender feelings in the mother which provide a satisfaction giving give-and-take between mother and child. In the presence of major difficulties on the mother's part there is inadequate gratification of the infant's needs and a resulting lack of satisfaction for those needs.

Using the example of a primitive genital phobia, Sullivan illustrated his point. He postulated the existence of zonal needs which call for satisfaction or gratification and ordinarily bring forth an appropriate response. A mother who is abnormally concerned with anal or sexual matters may become increasingly vigilant about any movement on the part of the child which threatens her—that is, she is overwhelmingly anxious about sexual and anal contamination of the body. The result will be strong, forbidding gestures whenever the child penetrates this sphere of anxiety. In response to the mother's anxiety, the infant experiences what Sullivan called "uncanny sensations,"[4] which impose strange taboos on the genital region. Accordingly, the genitals do not become part of the child's feelings of "my body." There arises a lack of sensations in conjunction with appropriate experiences pertaining to the genitals.

Sullivan's formulation, as described above, may be illustrated by the following case presentation. I interviewed a 9-year-old boy and his mother during a psychiatric consultation. The boy suffered from an extreme degree of phobic and obsessional disturbances. His mother was a nurse who had rigid notions of cleanliness and a morbid concern about contaminating certain parts of the body with anal, genital, oral, nasal and other excretions. She had devised a system of having a different colored washcloth reserved for a particular region of the body. One washcloth was to be used exclusively for the anal area, another for the genital region, a third for the neck, and so on. It so happened that the boy would occasionally mix up the colors and, for example, wash his neck with the washcloth reserved for the anal region. Such a step would evoke immediate panic on the part of the mother, who would become livid with rage and describe horrible consequences for this harmless transgression. As a result, the boy developed an extreme degree of inhibitory phenomena and a throttling of all spontaneity. The result was a case of severe phobia.

As previously noted, Sullivan did not consider phobias as a separate category but grouped them together with obsessions and doubts. The basic dynamic principle is referred to by him as obsessional substitution, a conspicuous and distressing difficulty in living. It refers to an individual who guards against experiencing severe anxiety by engaging in ritualistic, unproductive ruminations and thoughts. To this individual, spontaneous

feelings of self-affirmation, affectionate impulses toward others or an encounter in which he is genuinely approved of only lead to the intervention of anxiety. Tender impulses are readily transformed into hostile operations (malevolent transformation),[5] and spontaneous gestures of friendliness and acceptance are responded to in a highly defensive manner. The underlying core for this dilemma is postulated by Sullivan as a recurrent doubt on the part of the person as to whether the significant person in his life is basically accepting or rejecting him; the evidence always being divided in such a fashion that there is never any clarity as to predominant acceptance or rejection by the key figure.

Thus, it seems to me that Sullivan has added one important dimension to our understanding of phobic and obsessional disorders. He has stressed the basic distrust and self-doubt which the phobic and obsessional person experiences toward his own impulses and emotions and has emphasized a basic distrust of affirmative experiences as one of the primary factors in phobias and obsessions. In an operational way, phobias and obsessions are described by Sullivan as preoccupations which are a way of dealing with anxiety-producing situations or the threat of punishment. However, the concept does not stop at the level of an avoidance operation.[6] It also considers phobias and obsessions as isolating techniques. They isolate the person from any of his own emotions (that is, tenderness, anger, resentment) and create a powerful barrier in person-to-person contact. Interpersonal

situations involving phobic and obsessional components tend to minimize intimacy and foster a hostile integration. The result is a style of life in which tenderness and affection are repressed and concealed while preoccupations drain off a great deal of emotional spontaneity.

In recent years, some attempts have been made to reexamine our thinking about phobias. Arieti is of the opinion that phobias represent a general principle of psychopathology. He takes an existential point of view in speculating that human existence has become increasingly precarious and that man is constantly concerned with his fear of being in the world. Arieti suggests that concretization rather than displacement is the primary phobic mechanism. The concretization is an effort to symbolize experiences of profound anxiety. As an example, a sexual phobia may obscure the difficulty in sustaining loving relationships, a travel phobia may conceal a fear of venturing out into life, and so forth. In addition, he ascribes certain characteristics to phobias such as a "dehumanization of the emotional object, alteration of the emotional status, retention of active role and of reality test which can be correlated."

Salzman believes that psychologically phobias and obsessions "are more closely related to one another than would appear to be the case in view of Freud's position." He reinforces Sullivan's theory by stating that they frequently develop around the need

to defend oneself against tender impulses or the potential threats against feelings of pride or self-esteem. He also points to the necessity for distinguishing phobic avoidance operations from ordinary avoidance tendencies. According to Salzman, it is the failure to separate ordinary avoidance reactions from genuine phobias which is responsible for the markedly discrepant reports of success or failure in treating them.

Another significant point of view has been expressed by Spiegel, who has concerned herself with the vicissitudes of communication in various emotional disturbances. She has also called attention to a warp in the thought processes of obsessionals. Spiegel describes the intellectual thought disorder of obsessionals by stating, "The mesh of rationalization is often so firm and finely knit that it, surprisingly, often passes for genuine thought. The rationalization is actually comparable to a very mild delusional system with a faulty frame of reference." I would add to this that the faulty frame of reference is often to be found in the patient's familial pattern of thinking and frequently has its roots in the family dynamics.

Barnett places disordered cognition as central in the obsessional style of life. He views this type of person as a decidedly ineffectual thinker who suffers from inferential distortions.

The classic distinction between phobias and obsessions on the basis of

overt or covert anxiety has little meaning to me. Both reactions may be associated with morbid anxiety or the relative absence of it. The principle of displacement is not the specific property of phobic phenomena, nor is avoidance or manipulation of the environment an essential goal of people suffering from phobia. I agree with Arieti that phobias are concrete representations of more abstract anxiety-provoking situations and relationships. However, I consider the basic fears of the phobic person to be related to specific familial transactions. Accordingly, I do not accept the hypothesis that phobias are manifestations of the general psychopathological phenomenon of concretization. It is my opinion that phobias are similar to the night terrors experienced by troubled children who utilize such symbols as thunder, lightning, loud noise, bright light, unpleasant smells, etcetera, to refer to reactions to people they are afraid of. On the other hand, the symbols may refer to the network of confusing and threatening communicative messages within the family unit. It must be realized that these symbols are coded systems of communication representing disturbed interpersonal transactions. There is reason to believe that the symbols evoking terror in children are connected with powerful threats from the interpersonal environment. Freud showed us the way to appreciating the displacement of intense fear from a key person to a peripheral object. He demonstrated in his case history of Little Hans how the boy came to be afraid of a horse since he could not cope with his fear of his own father. However, Freud considered

infantile sexuality and the Oedipus complex to be the basic dynamic factor involved. Today we assume that there are many additional factors which play an important part in the presumed shift from a person to a symbolic representation by an animal or an inanimate object. The displacement is not from the father to a horse or from the mother to a mushroom cloud. Rather, it is from a pathologically charged field of communication to animate or inanimate phobogenic object. The basic threat lies in the menacing nature of the informational message and the morbid atmosphere of the family which does not permit alleviation of the anxiety. For example, a child may have been subject to extreme stress and strain by the milieu of a destructive marriage, a profound family pathology or by the exposure to a psychotic parent. Parental wrath may become so charged with anxiety that it assumes an independent representation by the child in symbolic form. The situation may best be illustrated by the following example. I had an opportunity to interview the mother of a young patient who suffered from numerous phobias. It turned out that the mother had undergone a psychotic episode when the boy was less than one year old. During her acute disturbance the mother experienced powerful impulses to kill her child, drop it "accidentally" or harm it in some other fashion. The patient had numerous nightmares in his preschool and early school years which undoubtedly were connected with his mother's menacing behavior at an earlier time.

In classical concepts, the initial threat originates inside of the person

because of instinctual demands which conflict with the reality situation. The result is a profound fear of punitive action if the underlying desire were to be pursued. Neoclassical concepts focus a great deal more on actual life experiences as the foundation for later difficulties. To my present way of thinking the phobic phenomenon is rooted in disturbed familial relations. The phobic symbol then becomes a metaphoric transposition of a morbid family atmosphere. The basic threat lies in the menacing nature of the informational message and the morbid atmosphere which does not permit alleviation of the anxiety.

Furthermore, there are indications that familial thought disorders have permeated the phobic person's thinking and have created disturbances in the realm of cognitive, perceptual and emotional processes. This particular formulation is similar to the concepts expressed by Spiegel and Barnett, except that I address myself directly to the origin of the thought disorder and trace it to particular family dynamics.

Other references appear in the literature which deal with the selection of phobic objects, the phenomenological point of view, the adaptational and behavioristic concepts of phobias. The reader is referred to the above references for a more detailed exposition of these points of view.

In summing up the prevailing psychological thinking on phobias, I

would like to add some additional thoughts. There has been a general shift in psychoanalytic thinking from focusing on intrapsychic processes to a transactional point of view. Even within the classic frame of reference the advent of ego-psychology has placed greater emphasis on adaptational and environmental factors. However, traditional psychoanalysis has attempted to embrace the best of two possible good worlds by maintaining the libido theory while becoming increasingly more conscious of here-and-now phenomena. The result has been a peculiar hybrid with a biological determinism on the one hand and a milieu-oriented concern on the other hand. The ego-psychology of Fairbairn, Melanie Klein, Schultz-Henke and others has stressed the central position of the ego and frequently emphasized the principle of introjection. The last mentioned concept represents an internalized process of an adaptational nature. It refers to experiences with other people which have been incorporated by the person. For instance a child may have taken on a mother's punitive attitude as if it were her own characteristic pattern.

A similar point of view is expressed in Sullivan's interpersonal theory. However, additional elements are added here. They may be condensed for brevity's sake into four interpersonal postulates: the ecology, anxiety, similarity and tenderness principles.

The ecology principle refers to the interdependency and

interpenetration of the organism and environment. It postulates the necessity for a never-ending active interchange between the human organism and it is essential milieu. The storage capacity for specifically human characteristics is limited and isolation from a specifically human surrounding is tantamount to mental illness. The ecologic principle also uses the construct of a transactional field as a central frame of reference.

The anxiety principle according to Sullivan specifies anxiety as a predominantly social phenomenon which is related to the encounter with other people. It is largely governed by the approbation or the lack of it by key persons who played a major part in the upbringing of the individual.

The similarity principle refers to Sullivan's much quoted statement, "We are all very much more alike than we are different, whether we are mentally ill or well."

The tenderness principle conceptualizes tenderness as a constructive, reciprocal mother-child transaction. It negates the instinctual aspects by focusing on the way a mother affects her child and vice versa.

The above constructs can be applied to the understanding of a variety of mental disorders. They represent certain fundamental conceptual postulates and must not be mistaken for everlasting truths about human nature. When applied to the phobic-obsessional disorders these basic interpersonal tenets

lead to the following concept.

The ecology principle is closely related to focusing our therapeutic attention on family dynamics. The interdependency of the child and its familial environment are viewed as the arena in which the foundation for faulty thinking and warped communication is laid. We find here the early medium through which the larger world is interpreted. There is frequently a misuse of words in families producing obsessive-compulsive disorders. Words tend to conceal true feelings and to distort many events in these settings. Thus, simple communication is rare and the transmission of information is frequently faulty. We also find in the family a sensitive system with its own equilibrium which tends to create images of all family members depending on the solidity or disturbance of the system. In troubled families irrational fears impinge on some members of the unit depending on the overall constellation of the family, on the distortions which are transmitted and a host of other factors. The ecology principle points to multiple variables which contribute to the formation of a phobic-obsessive disorder.

Next we encounter the anxiety principle. Here we are dealing with a very early aspect of the mother-child relationship whereby a highly insecure mother who may have inadequate emotional support from her husband transmits her own lack of self-esteem to the growing infant. The mother may have been disadvantaged by her own parents, a sibling, spouse or other

person and her “externally” induced anxiety then is passed on to the infant. Once anxiety is imprinted in the child it is there to stay as an ever-present factor of low self-esteem. The particular experience of anxiety distorts the child’s self-image and its perception of other people which takes on a particular character in the obsessive-phobic difficulty.

In regard to the similarity principle, we tend to approach the patient through familiar channels of common human experiences rather than emphasizing the gulf between the patient’s psychopathology and the therapist’s alleged superior mental health.

The tenderness principle applies to the understanding of the early mother-child relationship with particular emphasis on the mother’s capacity to respond to the child’s expressed needs in an appropriate fashion.

In conclusion I want to reiterate that I consider the genesis of phobias to be usually traceable to the network of communicative channels reflecting the relationships within the nuclear family.

I tend to view phobias as communicative difficulties in the presence of disturbed cognitive, perceptual and emotional processes. It is my contention that phobias have their origin in particular forms of familial misintegration. Each individual family member constitutes a subsystem with its own components, devices, goals and activities which, in turn, is connected with the

structure of the overall familial integration. This system has been referred to as *family dynamics* which, according to R. D. Laing, is "the interexperience and interaction of people living together united by affinity and kinship."

It can be very helpful in the treatment of phobias to focus primary attention on the warped method of transmitting information to the phobic person. In many instances, neither the sender nor the receiver of the message has a workable key for decoding the nature of the communication.

CLINICAL ILLUSTRATIONS

The above described conceptualization of obsessive-phobic phenomena forms the basis for a therapeutic approach to these disorders. To illustrate the treatment aspect, I offer some clinical vignettes pertaining to the topic under discussion.

Case I

A young married woman who is endowed with unusually high intelligence and a most pleasing appearance suffered from a severe phobia which had numerous manifestations. Her mobility was extremely curtailed by her fear of leaving her house. In addition, she had a major travel phobia, could not spend any time away from her husband, and went into a state of panic when he had to be out of town even for a single night. On such occasions, she

would hire a private nurse to spend the night with her. When she went to the theatre, she had to sit on an outside aisle near an emergency exit. She never permitted herself to go to a movie and took extreme precautions in all her activities.

Furthermore, she suffered from severe psychosomatic disorders and lived in constant fear of death. There was a distinct suspiciousness on her part in regard to all medications and to all medical doctors.

Her analysis was stormy but turned out to be successful in terms of her phobia. In the early part of treatment, she suffered an extreme degree of separation anxiety. She resented the analyst's absence, even for short periods of time and went into a decline when he went on a vacation. During his absence, she took to bed and did not once get up until he returned. A dream she had around that time illustrates her predicament by highlighting the extreme feeling of precariousness of her situation. She dreamt that she was on top of a high tower of a giant suspension bridge. There was a tent-like structure far up in the sky which was connected to the tower by a very narrow plank, and she required her husband's assistance to walk the "tightrope" back and forth between the tent and tower. The thought of having to make the crossing filled her with horror and panic.

The initial work consisted of reconstructing the family dynamics. It had

been the patient's impression that she had been doted on by her family. She had always felt very close to her mother to whom she was very attached. There were numerous memories of sitting in mother's lap even as a teenager, having her hair stroked and being treated as mother's favorite child. The father was described as being extremely fond of her; he lived away from home for a year's time when the patient was five years old. His absence was explained as having been necessitated by the unavailability of a suitable job in the community where the family lived. She recalls having missed her father greatly during that time.

The patient is the youngest of three siblings. She was born when her sisters were ten and twelve years old respectively. There was a close bond between the patient and the middle sister, who was always in very poor health and eventually died after a chronic illness. She identified a great deal with her and frequently felt in a superstitious way that she was also destined to die prematurely. The older sister became a kind of assistant mother to the patient.

As the analysis progressed, the concept of the nature of the family constellation changed considerably. Mother emerged as a chronically unhappy woman who felt trapped in her marriage. The mother became increasingly bitter and toward the end of her life unmistakably paranoid. We learned that one sibling had died as an infant and that the mother had blamed

the father for not taking appropriate action to save the child's life. From that time on the marriage deteriorated to a state of open hostility. There was also a state of constant warfare between the mother and the older sisters. Both girls were beautiful and had many suitors. Mother interfered with their romances and broke up one engagement after the other.

The patient had one previous marriage which ended in divorce. It never became quite clear why the marriage did not endure. What emerged, however, was the lack of an adequate motivation for having married in the first place.

In her early twenties, the patient spent a brief period away from home when she was relatively successful. However, she developed a major sexual phobia which broke up a promising relationship. Furthermore, she was extremely fearful of her health and suffered an episode of profound emotional and somatic disturbance prior to her second marriage.

Her second marriage encountered many difficulties; but in recent years has evolved as a basically sound relationship. In the early years of her second marriage the husband mothered her a great deal which evoked negativistic and outright hostile feelings on the patient's part.

As the analysis progressed, we observed a major change in her attitude toward her parents. She had a dream in which the mother and father were

both trying to kill her. Another time she dreamt that her mother was psychotic, and at a later point the father appeared in her dream as a dilapidated alcoholic who pleaded with her to be his sexual partner. About this time she came to feel much closer to the middle sister but had many anxiety dreams in which she suffered the sister's fate and died of consumption. Her attitude toward the older sister became more hostile.

Another crisis occurred when her husband became ill and required hospitalization; this forced her to stay by herself over a fairly long period of time.

The therapeutic relationship evolved into a situation of increasing trust. However, there were recurrent periods of severe doubt when she felt I had basically misled her and had failed to appreciate her genuine needs. These episodes were usually of short duration.

In the meantime, her freedom of movement has increased greatly. She is able to travel with a minimum of fear, and she has stayed by herself for long stretches of time without undue anxiety. It can be said that for all practical purposes, her phobia no longer exists; but she still has her share of difficulties in sustaining a close relationship. Nevertheless, the outlook is bright, and her overall state of well-being is remarkably good. There have been no recurrences of her frequent somatic episodes which paralyzed her and made

her bedridden for considerable periods of time.

COMMENTS. In reviewing this sketchy history, it should be clear that the patient's self-image and her role concept within her family were quite faulty. She saw herself as everybody's darling who had been particularly doted on by the mother. There was almost no awareness on her part of her morbid dependency on the mother. She did not appreciate the intense hostility between her parents which occasionally spilled over and made her the target of their violent impulses. While she was able to observe the mother's malice toward her sisters, she felt falsely immune to it. She came to realize that the middle sister died not only as a result of tuberculosis but just as much as a result of deadly familial interferences. Her fear of the oldest sister was an element she was slow to realize. The father's emotional and erotic involvement with her was illustrated by several events in recent years. Also, the mother's profound mental disturbance was not recognized by her until the time of the mother's death. Soon after she was able to reconstruct past experiences which indicated outright paranoid ideation on the mother's part, as well as direct physical threats against the patient. She recalled an episode where the mother displayed a murderous rage towards her when she was a young child.

In reviewing the salient factors in this phobic patient's life, I would like to stress the following points:

The patient grew up in a family atmosphere in which she experienced herself as the favorite child. She had no awareness of the deep-seated difficulties between her parents, the mother's discontent and suspiciousness, the father's instability and erotic preoccupation with her. Her own morbid dependency on her highly suspicious mother obscured an appreciation of the mother's violent anger. Furthermore, she was used by both parents in a destructive way as an object to divert attention from their own misery. Her alliance with the middle sister made her fear that she would suffer the sister's unfortunate fate. There was not one reliable ally in her early life. Her actual environment was filled with numerous threatening undercurrents which for the better part were carefully camouflaged. The phobias then seem to be a response to the inherent dangers in the family situation. What confronted the patient was a wall of misrepresentations and warped communications. She reacted to the situation as it actually was rather than to an inner impulse, relatively independent of her environment. Freud was disappointed when he realized that some of his patients had fabricated early traumatic situations. In our situation the opposite was true. The patient had great difficulty in recognizing the realistic basis for her seemingly irrational fears. She was largely unaware of the great hostility between her parents, the disturbance between the mother and her siblings as well as the father's maladjustments. She did not appreciate the faulty, familial network of communication and the resulting perceptual distortions on her part.

Case II

This patient is a pleasant young mother with two small children. She had been plagued by morbid fascinations of a highly disturbing nature. When alone with her children, she would suffer from agonizing obsessive thoughts which tended to increase in severity. For instance, her gaze would become fixed on the edge of a knife while she was cutting potatoes, and she would then experience an almost overwhelming urge to grab the knife and stab her children. It required every ounce of strength in her possession to resist the destructive impulse, and she would become exhausted from the effort.

Another problem consisted of an irresistible urge to read about crimes in the newspaper with the resulting compulsion to repeat the crime or place herself in the role of the victim. At such times she had to overcome the impulse to take a pair of scissors and stab herself in the throat. She became a self-imposed prisoner in her own home. Her phobia reached such severe proportions that she could leave the house only if accompanied by her husband or one of her sisters. In addition, she developed a claustrophobia; this prevented her from attending church which, in the past, had given her a feeling of solace. Neither could she attend social functions of any kind or visit with friends or relatives. It became necessary for her husband to bring her to my office for each visit.

She was one of four sisters, all of whom were victims of phobic-

obsessive reactions. It was a case of *folie a quatre.* Her oldest sister was the most phobic of the quartet; she was also possessed by an obsessive-compulsive mania. She insisted that her husband remove his shoes before entering the house; so also her two pre-teenage children. Her house was kept similar to the way in which a sterile operating room should be maintained. Everyone in the household was subjected to the most irrational cleansing rituals. It should be noted that this sister eventually developed an ulcerative colitis and died in an overtly paranoid state. The two younger sisters had severe phobic-obsessive difficulties. All four sisters were married and lived in close proximity to each other in a small suburban community where they had been raised.

The patient was seen in psychotherapy on a once a week basis for a period of about eight years. At present, she is still maintaining contact with me, averaging two to four visits per year.

She developed a childlike, dependent relationship with the therapist. There was a magical form of transference improvement in the beginning. I realized that I was dealing with a borderline psychotic state; but there was never evidence of decompensation on the patient's part. Her most severe symptoms subsided in a very short period of time, while her phobic symptoms remained relatively intact.

The first phase of therapy consisted of a variety of explanatory comments pointing to the concentration camp atmosphere in which the girls had been raised. We were able to understand her repressed hateful impulses based on the constant fear of reprisal and brutal abuse. The fatherless home, with an intimidated widowed mother, necessitated the oldest sister's maternal role; it also explained the closeness between the sisters and the symbiotic ties to the oldest one. Another fact emerged as time went on. The oldest sister had been placed in the position of the protecting, maternal wing; she had also assumed the role of scapegoat, who was often beaten for minor misdeeds of her sisters. The three younger girls worshipped the oldest one, and she became increasingly suspicious, for understandable reasons. However, her emerging paranoid ideation penetrated the thoughts of her siblings. The closest tie existed between my patient and the most severely traumatized oldest sister. We had to work through a morbid empathy which made her see the world through her sister's eyes. Progress in this respect was relatively slow. There was a temporary setback when the sister died. The patient had a difficult time separating her own feelings and thoughts from her powerful ally in childhood and her unwitting tormentor in adult life.

The final phase in treatment centered around the patient's dependent relationship upon her husband. Many of her ties to her sister had found their way into this relationship. She harbored numerous resentments toward her husband, who had become "her eyes and ears" in regard to the outside world.

It is of interest that the husband became markedly disturbed when the patient loosened her symbiotic ties to him. He began to drink heavily and came close to assuming the uncle's role. The situation has been resolved reasonably well. There is no longer evidence of the original morbid obsessions; her phobia has subsided, and the only remnants of her emotional difficulties are brief periods of moderate depression.

COMMENTS. A review of the therapeutic process indicates that the initial task consisted of establishing a mode of communication which bypassed or transcended her anxiety-fraught preoccupations. It became necessary to link her morbid ideation, her obsessions and phobias, to environmental, familial events. I did not hesitate to point out behavioral and attitudinal patterns within the framework of the familial situation. The husband was invited to participate in several sessions, as were the patient's sisters and some of their respective husbands. We were able to pool information with her siblings and learn a great deal more about the mother and her relationship to the uncle, as well as about the more durable alliances in the family unit.

Case III

The patient is a young single woman who embarked on a successful career immediately after leaving college. She entered analysis in a state of

profound depression. There was evidence of marked obsessive doubting which reached a state of outright confusion. The patient had resigned from her job and could not make a decision about choosing one boyfriend or another. Her plans were to get away from it all and travel around the world.

The patient had had a sheltered childhood and was considered to have been a beautiful and highly intelligent youngster. She was never really denied anything by her mother, who centered her life around her and called her "Princess."

At the time of puberty, the patient developed an acute school phobia which kept her at home for a period of many months. She had always been an outstanding pupil and could not explain her phobia about attending school. Combined with this, she developed several other phobic reactions. For instance, she insisted that all Venetian blinds in the house be closed so that nobody could look inside. Furthermore, she would lie flat on the floor of the car when she went out with her family. Her fear was that people would see her; but she could not explain why she thought that people should not see her. She recalled a recurrent nightmare which she had at that time in her life. It consisted of the appearance of a withered, claw-like hand with very long, sharp fingernails. There was something infrahuman about this hand which caused eerie sensations. It is interesting to note that her well-to-do family did not see to it that she received professional help at the time of her severe

disturbance. Eventually, her symptoms subsided and the patient went back to school.

There is still today an air of unreality about this episode which has never been clearly understood by the patient. She has many rationalizations in retrospect; but there is a basically ego-alien quality to her phobic reaction. A fugue-like character is present in the quality of the psychopathological phenomena which occurred at the threshold of adolescence.

The patient is a highly competent person with a tendency toward fragmentization. Many of her emotions and thoughts are relegated to compartments without the existence of an obvious nexus. She gives the appearance of an independent person which, on closer inspection, proves to be a faulty impression. Her family ties are deep and complicated.

There is one older sister who always had an alliance with the father, while the patient was overly involved with her mother. The parents have never been very happy with each other; the mother confided in the patient on many occasions that she lived exclusively for her two children. It became clear to the patient, however, that mother had eyes only for her and treated her the way a lover would behave toward his love object. There were constant clashes between the patient and her father over financial matters, attitudes toward way of dressing, behaving, etcetera. These were

undoubtedly fostered by the mother, wittingly or unwittingly. As far as she was concerned, the patient could do no wrong. Father tended to be cautious about money, and mother would deceive him about the sums she spent on her daughter. They would secretly take taxis together without letting father find out or buy expensive clothing for the patient and make it appear as if little money had been spent for the dresses.

Mother had made it known to her daughter that she did not have respect for the father, who was highly dependent on the mother. In addition, the mother was very close to her own mother, who lived in the same household with them during the patient's childhood. The grandmother was a domineering woman who did not get along with the patient's father. She was a most distrustful woman, with numerous superstitions and prejudices.

The patient's sister married at an early age in order to get away from home; the patient remained single until her middle thirties, in spite of frequent marital proposals. She had a phobic attitude toward marriage and had a great deal of difficulty in sustained contact in love relationships. There is an almost total absence of personal rapport between the patient and her sister.

In the analytic situation, the patient found it difficult to be productive or relate in a personal manner. There was also a considerable degree of passivity

which constituted a formidable resistance.

It was in connection with the analysis that some tension developed between mother and daughter. The mother overstepped her boundaries and had her first major fight with the patient. Shortly after this upsetting encounter, the patient had a revealing dream.

The main character in the dream was a woman who had been a neighbor when the patient was growing up. This woman had a flower garden which she guarded jealously. One day the patient, at the age of five, went over and picked one little flower, whereupon the woman turned into a witchlike creature who displayed a rage of probably psychotic proportions. The incident frightened the patient to the extent that she could still recall the details of the episode as an adult. In the dream, Mrs. Brown (the neighbor) appeared, her face contorted with rage, and she shouted very unpleasant things at the patient.

Her association to the dream was to link Mrs. Brown and her mother. It came as a genuine surprise to her that her mother was capable of being irrationally angry. There is little doubt that she must have encountered mother's uncontrolled rage as a child; however, she had pushed this memory out of her awareness. She had seen mother become very angry at father but had not recalled having been the target of mother's wrath in the past.

COMMENTS. The above-described patient had a major phobic reaction during her early adolescence. In adult life, she was relatively symptom free in terms of phobia, but she suffered from a severe obsessive neurosis. She did not receive any kind of treatment for her phobia. It stands to reason that every therapist, regardless of his school of thought, would have claimed success in treatment (if the patient had gone to see such a person). Be that as it may, there is no doubt about the severity of her obsessional disorder. Treatment is still in progress; the results up to this time are somewhat disappointing. There is a deeply entrenched schizoid core which has combined with the obsessional dynamism and resisted a major breakthrough thus far.

SUMMARY

In this chapter phobias have been presented as thought disorders which are closely related to obsessional states. It was suggested that phobias and obsessions be viewed as one clinical entity rather than two separate conditions. Subsequently, the obsessive-phobic syndrome was discussed in terms of (a) its interpersonal misperceptions, (b) its communicative malfunctioning and (c) its informational distortions. The underlying obsessive-phobic thought disorders were traced to the maladaptation and malfunctioning of the nuclear family unit.

Particular emphasis was placed on the warping of the self-image as well as on the inaccurate evaluation of how the obsessive-phobic person is seen by other people.

Phobias and obsessions were viewed as a particular lack of basic trust with a corresponding conflict as to whether the most significant person in one's life is friend or foe. As part of the chronic doubting and ambivalence, phobic-obsessional people distrust spontaneous feelings of tenderness in themselves and others. They are easily prey to malevolent transformation which represents a defensively hostile reaction to feelings of affection and intimacy. Another interpersonal characteristic of this disorder is a masking and denial of a highly dependent way of relating to other people.

Impairments in the process of communication and cognition were pointed out resulting from faulty communicative channels in the initial, familial setting. The difficulties pertain both to the way in which messages are communicated as well as to the content of the message. Accordingly, obsessive-phobic thought disorders are related to miscarriages in familial communication.

Some obsessive-phobic manifestations are discussed with particular reference to faulty information about family relations in the initial recollection of early life experiences. The presence of realistic danger in the

past is pointed out which is not recognized in the patient's awareness.

In the discussion of treatment, reference was made to Freud's famous case of Little Hans. It was pointed out that Freud did not consider the subsequent divorce of the boy's parents as a significant factor in the dynamics of the child's phobia. Our present frame of reference emphasizes the disturbed, marital relationship as a key element in the formation of the boy's irrational fear. Today there is less stress on the intrapsychic, Oedipal conflict as the central, neurotic disturbance compared to the reactive, adaptational manifestations within the malfunctioning of the familial unit. Therapy focuses more specifically on the family network of communication and the resulting warpings in perception. The therapeutic task includes an appreciation of the underlying thought disorder with its concomitant relational, cognitive and emotional distortions. A thorough reevaluation of the explicit and implicit roles within the family unit is also necessary in order to understand potential miscommunications and misperceptions among the family members. Many reality factors are stressed which may account for certain deviations in thought, attitude and behavior.

Three clinical illustrations were offered which were designed to highlight various aspects of treating phobias. In all instances, an effort was made to place the family dynamics in the center of the therapeutic approach. An attempt was made to decode the complex symbolic messages in terms of

familial experiences.

The problem of dependency came in for its share of attention. Much time was devoted to exploring the nature of communicative patterns in the analytic situation as well as in daily life. Under certain circumstances, relatives, friends and other persons of significance were invited to meet jointly with the patient and analyst. It was found that once the phobia yielded to therapeutic intervention, other personality difficulties came to the fore. One case was reported in which there was a spontaneous recovery from a severe phobic reaction in adolescence, with the emergence of a pronounced obsessional disorder.

Notes

1 This is in contrast to Sullivan who means by isolation a form of withdrawal from people.

2 It is of historic interest that the boy's father was the therapist in this case, in spite of the fact that he was the principle source of the boy's fear. There is another significant aspect to the situation which, to the best of my knowledge, has not been commented upon. In a postscript to the case of Little Hans, Freud casually mentions that the boy's parents were eventually divorced. It would be inconceivable in modem psychiatry to ignore the effect which the parental marital disturbance must have had on the boy's evolving anxiety. A study of family dynamics in the case of Little Hans would have shed considerable fight on threatening components in the family's relational structure. A detailed knowledge of the integrational familial patterns might have lead to a different formulation of Freud's famous case illustration in regard to the genesis and dynamics of phobia.

3 The term "algolagnia" is derived from the Greek word *algos* and refers to people who have a compulsion to expose themselves to painful situations. It is a particular form of sadomasochism which clinically forms part of a complex that includes obsessional,

phobic and paranoid syndromes. There is a link between all four of the above-mentioned conditions and under certain circumstances the same patient can manifest all these symptoms.

4 Experiences of awe, dread, horror and loathing attributed to the abrupt intervention of severe anxiety.

5 The need for tenderness has been transformed into a feeling of hostile anticipation.

6 Avoidance operation refers to activities designed to avoid exposure to a dreaded situation or object.

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