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Daniel E. Weinbaum
Theorizing Anxiety: A
Psychodynamic Exploration
Beyond the Medical Model

ABSTRACT

This theoretical study explores the phenomenon of anxiety and how it has been understood, articulated and treated over time in psychoanalysis. Formulations of anxiety in classical theory, object relations, attachment, interpersonal, relational and trauma theory will be explored, offering a counterpoint to the current medical model in which anxiety is primarily understood as a symptom to be eradicated through medication and “evidence based” treatments. The study argues that anxiety only exists within a relational and systemic context, and that reducing anxiety to a set of discrete disorders requiring prescriptive treatment protocols often overlooks the complexity of individual experience and need as well as discounting psychodynamic treatment options that are also effective. Finally the study will end with a composite case study that further illustrates the theories discussed, and that also demonstrates the functions and meanings of anxiety within a relational context.

THEORIZING ANXIETY:
A PSYCHODYNAMIC EXPLORATION
BEYOND THE MEDICAL MODEL

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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CHAPTER I

Introduction

. . . I believe that it is fairly safe to say that anybody and everybody devotes much of his lifetime, a great deal of his energy . . . and a good part of his efforts in dealing with others to avoiding more anxiety than he already has and, if possible, to getting rid of this anxiety (Sullivan, 1953 P.11).

If one embraces Sullivan's understanding of anxiety as central, if not **the** central, phenomenon shaping human behavior and relationships, then the study of anxiety, its functions, and its role in clinical work would seem to be indispensable. Various psychoanalytic theories from Freud onwards have grappled with theorizations of anxiety and its role in human development and relationships. These include ego psychology, object relations, and attachment theory as well as contemporary relational and trauma theory among others. An examination of these theories will offer insight into the etiology of anxiety, its adaptive functions in development and survival, its underlying role in many types of pathology, as well as the ways that it informs clinical practice. Anxiety and its functions, like all affective experience, remains intangible and difficult to define, and in this sense always remains beyond explanation or theorization. Perhaps the

ongoing preoccupation with anxiety as a phenomenon within psychology and mental health is rooted not only on the ubiquitous nature of its presence, but in the impossibility of defining its place and function.

Despite the elusive nature of anxiety and the complex and often contradictory ways that anxiety has been understood within psychoanalysis, few concepts have been more central to the development of the field of psychology, including its most recent incarnation within a medical model. Currently, forms of anxiety are the most commonly diagnosed set of discrete disorders (second only to depression) within the medical model that dominates mental health practices in the United States and most other parts of the world.

This theoretical study is concerned with examining psychoanalytic formulations of anxiety that challenge the current hegemonic notion of anxiety as a discrete disorder, positing it instead as an integral aspect of human development and relationships. Chapter I examines the scope of anxiety as a disorder within the medical model, its prevalence and the populations it effects, as well as the treatment practices most commonly used to reduce or to eradicate it as a symptom. This chapter will also provide a literature review of various empirical or evidence-based studies conducted on anxiety disorders and their treatment. The chapter will focus on the empirical viability of psychodynamically oriented treatments compared to behaviorally oriented treatments such as CBT or the use of psychiatric medications that have become the treatments of choice within most mental health systems in the United States and internationally.

Chapter II will then trace the history of key psychoanalytic formulations of anxiety that inform current treatment practices. The chapter will begin with classical

Freudian theories about anxiety along with Melanie Klein's object relations framework. Anxiety in Winnicott's self-psychology and Bowlby's attachment theory will also be examined. Chapter III will explore how theorizations of anxiety inform the increasingly dyadic focus of Harry Stack Sullivan's interpersonal theory. The next section of this chapter will examine how relational theorists such as Stephen Mitchell integrate object relations and attachment theories with interpersonal theory creating a dyadic and decentered approach in which anxiety can only exist within a relational matrix. Phil Bromberg's relational conception of multiple self-states and processes of dissociation will also be explored.

In the final discussion, Chapter IV, I will use a composited case study drawn from experiences in my most recent placement at a college mental health center in order to illustrate the theories previously discussed, with a focus on how anxiety functions and becomes an integral part of treatment within a relational psychodynamic approach. One of the primary reasons I chose anxiety as a focus of this study is the very high prevalence of anxiety symptoms within this population and setting. The counseling center where I was placed was by definition a brief treatment clinic. This case study will also explore the ways that systemic expectations and demands shape treatment options as well as the kinds of enactment, rupture, and repair that are a central feature of psychoanalytic treatment. In conclusion, this chapter ends with an argument for the necessity of a range of treatment options that both reduce anxiety as a symptom, but that also offer alternatives to the dominant medical model that often rigidly defines forms of anxiety and provide corresponding treatment practices that do not necessarily meet the needs of the patient or the community of which they are part.

CHAPTER II

On the Phenomenon of Anxiety

Statement of Problem, Scope and Populations Affected

The National Comorbidity Survey-Replication conducted from 2001-2003 to gather information on mental health disorders in the United States found that 28.8% of the general population meets criteria for at least one of the following anxiety disorders: panic disorder (PD), agoraphobia (AGO), social phobia (SAD), post-traumatic stress disorder (PTSD), and generalized anxiety disorder (GAD) (Himle et al, 2008). According to an analysis of the NCS-R data by Kessler et al. prior to the release of the DSM-V, anxiety disorders have one of the highest rates of lifetime prevalence second only to major depressive episodes (2012). The lifetime morbid risk (LMR) for a major depressive episode is 16.6% while the LMR for anxiety disorders is as follows: 15.6% for specific phobias, 10.7% for social phobia, 6.7% for social anxiety disorder (SAD), 5.7% for post traumatic stress disorder (PTSD) (Kessler et. al, 2012). The less common anxiety disorders are generalized anxiety disorder (GAD) with an LMR of 4.3%, panic disorder (PD) without agoraphobia at 3.7%, agoraphobia with or without panic disorder (AGO) 2.5% and obsessive compulsive disorder (OCD) 2.3% (Kessler et. al, 2012) The diagnostic prevalence of anxiety disorders in the United States underscores the importance for social workers, policy makers, and other mental health professionals, of

understanding the etiology of anxiety, its clinical implications, and theoretical frameworks.

In their research on psychodynamic treatments for anxiety disorders, Slavim-Mulford and Hilsenroth (2012) write:

Anxiety disorders are associated with severe impairments in functioning and have significant emotional and financial costs both on personal and societal levels. For example, patients with panic disorder have higher rates of morbidity and health care utilization than patients both with and without other psychiatric disorders leading them to account for 20% of all emergency room visits. Similarly, when compared with people suffering from 25 other mental disorders or common physical conditions, people with a diagnosis of GAD report missing the most work. Thus, given the high prevalence, impairment, and cost of anxiety disorders, it is essential to continue to develop and test treatments for anxiety (p. 117).

According to the NCS-R and the Adolescent Supplement (NCS-A), Kessler et. al. found that anxiety disorders are common to both men and women, but that women are at increased risk for all anxiety disorders (2012). In the cases of GAD, AGO, SAD and PTSD, women reported close to or more than twice the lifetime prevalence to men for these disorders. Most anxiety disorders have the highest lifetime prevalence for adults between the ages of 18 and 64. However, all population groups had the highest rate of onset for GAD, SAD, PD, PTSD and AGO in the late teens through the early twenties. Living below the poverty level, fewer years of education, and being divorced, separated, or never having married all increased the odds for different 12-month anxiety disorders.

Using the NCS-R data, several studies have also examined the rates of anxiety disorders among different ethnic and racial groups in the US. Breslau et al. found that non-Hispanic whites had significantly higher rates of GAD compared to non-Hispanic blacks or Hispanics (2006). Whites also had higher rates of PD and SAD compared to other groups. In their comparative study of anxiety disorders in African Americans, non Hispanic whites, and Caribbean blacks, Himle et al. write that “Increased risk for most anxiety disorders among whites remains somewhat counterintuitive given increased social and economic stressors experienced by blacks” (2009). The authors posit several hypotheses to explain this phenomenon. The authors also found that, while the rates for anxiety disorders were lower in general among African-Americans and Caribbean blacks compared to whites, the lifetime prevalence for PTSD was higher for these two groups than for whites. Furthermore, Himle et al. found a significant correlation between race/ethnicity and the severity of mental illness for all anxiety disorders except agoraphobia (2009). Whites reported the lowest levels of functional impairment compared to African Americans and Caribbean blacks, and Caribbean blacks had the highest proportion of cases in the severe category (Himle et al., 2009). In another study that examined the relationship between race-based discrimination and non race-based discrimination and GAD, Soto et al. found that non race based discrimination was a predictor for GAD for all groups, but that in particular race-based discrimination was associated with higher odds for predicting lifetime GAD only for African Americans (2011).

A fuller discussion of the complex relationship between race, gender, class, age, and anxiety disorders is beyond the scope of this phenomenon chapter, but the existing

data raises important questions about the socially constructed nature of mental illness, including anxiety disorders. Likewise, the data also raises important questions about the relationship between race, socio-cultural, and socio-economic factors, and how these inform etiology. The prevalence within different population groups may also be less an expression of the quality of lived experience and more an expression of how states of being are perceived by many individuals within groups and by the mental health professionals who treat them.

Treatment for Anxiety Disorders

While the identification of anxiety disorders and their diagnostic prevalence serves the useful function of framing their social and psychological significance and the need for treatments, these diagnoses also highlight the degree to which anxiety is now understood within a medical model. Anxiety as a phenomenon is predominantly thought of as a set of disorders with related symptomology. One result of this is a turn to psychiatric medication and/or cognitive behavioral therapies and interoceptive exposure therapies aimed at eradicating or reducing unwanted symptoms. Alongside the use of medications, CBT and other cognitive and exposure therapies are now considered the “gold standard” in the treatment of anxiety. One of the most widely studied treatment protocols developed by Barlow and Craske utilizes breathing retraining, cognitive restructuring, and in vivo exposure in addition to IE (interoceptive exposure) (2008). Several clinical trials have worked to demonstrate the efficacy of this treatment protocol, and several other studies add onto or recalibrate this protocol to improve outcomes in cases where the treatment is not effective (Welsh et al., 2010). Cognitive behavioral therapies are now the most common form of treatment for anxiety in the United States

and abroad. An international comparison survey of different psychotherapeutic theoretical orientations demonstrated, with a few exceptions, that CBT is the most common treatment for anxiety in most parts of the world (Hoffman S. et al, 2010).

In his book *Crazy Like US: The Globalization of the American Psyche*, Ethan Watters argues that through processes of globalization, Western mental health has now shaped the conceptualization of mental illness in most of the world such that the DSM has become the “worldwide standard” (2010). Watters (2010) writes that

how people in a culture think about mental illnesses – how they categorize and prioritize the symptoms, attempt to heal them and set expectations for their course and outcome – influences the diseases themselves. In teaching the rest of the world to think like us, we have been, for better and worse, homogenizing the way the world goes mad (p. 2).

While Watters is most concerned here with Western homogenization of mental illness, his logic can equally be applied to the United States and anxiety disorders. Indeed the conceptualization of anxiety as a set of individuated disorders based on certain symptomology, and the treatments used to target those symptoms, undoubtedly effects the prevalence and presentation of those disorders in America and how different population groups understand and experience the nature of their own mental health. Yet it is important to point out that the specificity and prevalence of anxiety disorders not only reflects an “era of anxiety” and its dialectical relationship with the mental health classification system, but also the growing body of professional knowledge based on research and clinical experience that informs the constantly evolving nature of diagnosis and treatment. The diagnoses of Panic Disorder and Panic Disorder with Agoraphobia

only became distinct diagnostic categories differentiated from free-floating anxiety with the release of the DSM III in 1980 (Craske and Barlowe, 2008). The increasing precision of diagnostic criteria points to both the nuanced differentiation of clinical presentations over time and the evolving and contingent nature of diagnoses. Likewise, treatment options reflect the focus on and prioritization of certain symptoms.

Literature Review

While there is ample research and clinical data demonstrating that CBT and medication can be effective in helping patients manage and reduce anxiety symptoms, the increasing focus on CBT and medication is part of the medical model's prioritization of symptoms that often ignores the full complexity of individual biopsychosocial make-up. Furthermore, psychoanalytic formulations and treatments that may be equally if not more helpful to some patients than CBT are increasingly devalued and shunted aside for what are now viewed as more cost effective, evidence-based treatments.

However, a recent comparative study of the longterm effects of CBT and Short Term Psychodynamic Therapy (STPP) for the treatment of GAD (generalized anxiety disorder) revealed that both produced large improvements at the 12 months follow up (Salzer et al, 2011). However, in terms of worry and trait anxiety, CBT was found to be superior. The Hamilton anxiety scale was used as the primary measure, and treatments were carried out for both CBT and STPP according to manuals. The study began with 57 participants diagnosed with GAD, and only 41 followed through with treatment until the 12 month follow up. The small sample size of the study limits its generalizability, and the focus on worry and exposure to worry that is part of the focus in CBT raises the possibility that an increased focus on exposure to worry in STPP may improve outcomes

in terms of trait anxiety and worry. However, the authors also point out that, in psychodynamic therapy, worry is often conceived of as a defense that protects the client from other feelings or conflicts, and so the focus on worry itself would then become a distraction from emotional states and fantasies that are more threatening than the worries themselves (Salzer et al, 2011). In this regard, a focus on symptom reduction as opposed to a broader range of affective experiences of self in relationships can also skew the perceived benefits of psychodynamic treatments.

While there have been several studies of the efficacy of STPP for anxiety disorders, none of them were structured with sufficient inter-rater reliability to make them generalizable. In response to this lack of empirical stringency, Slavin-Mulford et al. (2011) designed the first study of the efficacy of STPP with acceptable inter rater reliability to examine how specific therapeutic techniques related to changes in anxiety disorder patients. The authors (2011) also point out that there have been few treatment studies that accurately examine the specific treatment strategies that produce patient change in CBT. Slavin-Mulford et al. (2011) used the Comparative Psychotherapy Process Scale to assess fidelity to certain therapeutic techniques and how they produced change. Self-report scales for symptoms and level of functioning in different domains along with external therapist reports were used to determine the efficacy of treatment at various stages of therapy. Significant adaptive changes were found in anxiety symptoms, global symptoms distress, interpersonal distress as well as social occupational functioning. Over the course of treatment, 76% of patients reported anxiety symptoms within a normal distribution, which is an improvement over past CB and psychodynamic studies. Four therapeutic techniques in particular were meaningfully related to outcomes

(Slavin-Mulford et al., 2011). These include 1) focusing on wishes, fantasies, dreams and early memories; 2) linking current feelings to perceptions of the past; 3) highlighting patients typical patterns; 4) helping patients to understand their experiences in new ways. All of these techniques are consistent with psychodynamic theories. Like the previous study by Salzer et al. (2011), a limitation of this study is its generalizability due to the small sample size of 21 patients. Six of these patients were also stabilized on anxiolytic and/or antidepressant medication for three months prior to treatment, but were included in the study because they requested additional treatment to meet their personal goals.

A 12-month comparison study by Ferrero et al. (2007) of brief psychodynamic, psychotherapy, and pharmacotherapy for patients diagnosed with GAD in a community setting, shed more light on the efficacy of medication and psychodynamic therapy. This study sample included 87 patients with GAD with or without an Axis I and Axis II comorbidity. The aim of the study was to assess the 6 month outcome of patients being treated with Brief Adlerian Psychodynamic Psychotherapy B-APP, a version of STPP, compared to pharmacologic treatment or combined treatment. There was also a 1-year follow up to determine the maintenance after six months of ending treatment. Multiple measures were used to track patient progress including the Clinical Global Impression (CGI), The Hamilton rating scale for anxiety and depression, The Social Occupation Functioning Scale (SOFAS) and The Verona Satisfaction Service Scale. Because medication is currently the primary treatment offered to patients with GAD at most outpatient clinics due to the perceived expense of long term psychotherapy, Ferrero et al. (2007) wanted to assess the effectiveness of B-APP compared to medication alone or medication combined with therapy. Results showed that both therapy alone and

medication alone yielded relative good remission rates for GAD (67% and 63% respectively) at the one year mark. Medication combined with therapy yielded 80% remission rates at the one year mark. Of note, subjects with personality disorders who were treated with B-APP were more likely to exhibit improved socio-occupational skills. The authors conclude that B-APP is an effective monotherapy for GAD, and for patients with more severe GAD or a comorbid personality disorder, B-APP combined with medication is often most effective. One limitation of this study is that B-APP is non-manualized, but the authors point out that some studies have demonstrated that non-manualized treatments are as effective as manualized ones. Another limitation is the small sample size, even though this study has a much larger sample than most studies on the treatment of GAD.

While all of these studies focus on the use of different forms of STPP, in another study conducted by Knekt et al. (2008), a group of 326 outpatients diagnosed with either an anxiety disorder or depression were randomly assigned to either STPP, solution focused therapy, or long term therapy in order to determine the efficacy of these treatments on work ability for patients with psychiatric disorders. In order to measure efficacy, the study used the Work Ability Index, (WAI), the Work Subscale (SAS-Work) of the Social Adjustment Scale (SAS-R), the perceived Psychological Functioning Scale, the prevalence of patients employed or studying, and the number of sick-leave days. The study found that work ability was significantly improved according to all of these measures during each phase of the 3-year follow up. There was no significant difference between the two kinds of short term therapy, but these two therapies showed 4-11% improved work ability at the 7 month follow up over long term therapy. At the second

year follow up there was no difference between therapies. However, at the third year follow up, test scores for long term therapy showed 5-12% improvement indicating that while short term therapies produce quicker improvement, long term therapies produce greater longevity of benefits over time. As with the other studies of psychodynamic therapy previously discussed here, due to ethical considerations there was no control group. Treatment was also not manualized, and whether or not this reduced reliability of the study remains a debated issue.

A literature review by Blagys and Hilsenroth (2002) of existing comparative studies of CBT versus psychodynamic-interpersonal therapies (PI), aimed at distinguishing the specific characteristics of CBT from other therapies in order to determine the relationship of these techniques to outcomes. The authors suggest that recent research investigating the relationship between CBT interventions and patient outcomes have yielded discrepant results. They argue that some of the positive correlations between CBT techniques and patient improvement are not related to specific cognitive interventions. Rather several studies that they reference from the literature suggest that techniques employed from PI are increasingly used in CB therapies and account for some of the positive outcomes. These include a greater emphasis on the therapeutic relationship, exploration of defensive processes, an emphasis on patients' affect, an acknowledgement of unconscious processes in human experience, and an increased focus on patient's developmental experiences. Along with the increasing overlap in therapeutic techniques, the authors identified six characteristics that distinguished CBT from PI. These include an emphasis on homework, direction of session activity, teaching skills to cope with symptoms, focus on patient's future

experiences, providing patient with information about treatment and his or her disorder, and a focus on the patients' cognitive/intrapersonal experiences. It is important to note that in several studies reviewed, patient improvement was not strongly correlated to changes to maladaptive cognitions, which traditionally has been considered one of theoretical cornerstones of CB therapies.

Langmore and Worrell (2007) continue to build upon this analysis and examine critically the empirical anomalies in the literature. They identify three anomalies in the literature. First, there is little evidence that changing cognition improves outcome. Second, CBT is often associated with rapid and early improvement in symptoms that most often likely occur before the implementation of any specific cognitive techniques. (It is useful to note here that, in their study of STPP treatment for anxiety, Slavin, Mulford et al. (2011) found similar reports of rapid patient satisfaction and a feeling of confidence in their ability to improve their symptoms at the third or fourth session.) Third, cognitive mediators do not seem to precede changes in symptoms. In framing their analysis of these anomalies, the author's posit that researchers are increasingly:

proposing that multi-level cognitive architectures provide a more accurate description of human cognition. For example, Brewin, in his recent M.B. Shapiro Award Lecture (Lawson 2005) questions the proposition that challenging thought leads to changes in feelings and behaviors. Drawing on the finding of cognitive science, he proposes that human cognition comprises multiple memory systems and knowledge stores, not all of which are open to introspection. Further, he suggests that these multiple systems give rise to multiple self-representations. He concludes that

therapy is better employed as a constructivist strengthening of more helpful representations rather than a logico-deductive challenging of unhelpful representations. . . .Likewise for Teasdale (1997)therapy should focus on the clients “actual way of being” (p.150) rather than logically challenging beliefs (p. 174).

A summary of component analysis of the literature led Longmore and Worrell (2007) to conclude that cognitive interventions provide little or no added value to behavioral interventions. While the authors reassert the effectiveness of CBT, they also emphasize CBT’s status as an empirically grounded therapy, and call for further research on what specific techniques are most effective in the treatment of disorders if changing cognitions themselves is not the basis for improvement.

While this analysis of the literature argues that there is no clear indication that treatment outcomes for CBT are any better or more evidence-based than psychodynamic ones, the terms “evidence based” and “CBT” have over time become almost synonymous. One primary reason for this is that CBT, at least in theory if not practice, can be manualized in a way that many psychodynamic therapies cannot. In a recent article titled “Where is the evidence for evidence based treatment?”, Jonathan Shedler (2013) critiques a review of a CBT study in which the reviewers uncritically state that outcomes in the study would improve if the clinicians who practice CBT strictly adhered to the protocols laid out in manuals, when in fact no data was collected offering evidence to support this claim. Shedler points to the unexamined set of unsupported assumptions about effective treatment practices that underlies this analysis. Shedler further argues that experienced clinicians change and modulate their approach

based on their experience of what helps patients. He also asserts that most clinicians who practice CBT rely on psychodynamic practices as well. A survey of CBT clinicians shows that the vast majority of them choose to see psychodynamically-oriented therapists for their own therapy and the influence of their own therapy on their work cannot be underestimated (Wachtel, 2011). Thus, the conflation of CBT with evidence based practice and the growing exclusion of psychodynamic approaches within the medical model of treatment relies on arguments that are often not supported by any evidence.

Rationale and Clinical/Policy Implications of Project

While the preceding literature review serves the useful function of examining some of the “evidence,” my purpose here is not to argue against CBT, or to claim that psychodynamic therapy is more effective, but to propose that an exploration and reevaluation of a core concept such as anxiety and its place in treatment can destabilize the dominance of the current medical model in which patients are too often problematized and reduced to their symptoms. My own focus on empirical evidence in this phenomenon chapter in order to assert the validity of psychodynamic treatments, clearly obviates my biases and how they inform this study. This focus also reproduces some of the closed logic that underpins the current loss of a more holistic, spiritual and socially conscious approach to mental health that is also part of the medical model. However, in subsequent chapters I hope to expand this framework; I will explore the concept of anxiety historically and conceptually within classical theory, interpersonal psychology, object relations, attachment, relational, and trauma theory, in order to shed light on the etiology, functions, and clinical utility of anxiety not only as a symptom or diagnosis but as in as an integral part of development and treatment. My hope is that a

multifaceted approach to understanding anxiety can destabilize and expand the narrow rationales and logic behind current treatment trends.

My other hope is that this project will help erode some false divides between treatment practices so that each can borrow from the other without unnecessary judgments. Furthermore, many insurance companies only offer limited coverage when it comes to mental health. Since social workers often work within agencies and large systems where a combination of time pressure, financial concerns, and patient/community socio-economic status dictate forms of available treatment, valuable psychodynamic theories and practices that cannot be manualized or that may require more sessions, may increasingly get lost. Nowhere is this more evident than in the current medical focus on anxiety as a symptom and a disorder divorced from its other complex functions and meanings for the individual within his or her internal and external social context.

CHAPTER III

Psychoanalytic Theorizations of Anxiety: Classical Perspectives, Object Relations and Attachment Theories

In the case of external danger the organism has recourse to attempts at flight. . . . Repression is an equivalent of this attempt at flight. . . . The problem of how anxiety arises in connection with repression is no simple one; but we may legitimately hold firmly to the idea that the ego is the seat of anxiety and give up our earlier view that the cathectic energy of the repressed impulse is automatically turned into anxiety (Freud, 1926, p. 92).

No concept is more central to psycho-analytical theory than the concept of anxiety. Yet it is one about which there is little consensus All analysts are agreed that anxiety cannot be explained simply by reference to external threat: in some way processes usually thought of as internal and instinctive seem to play a crucial role. But how these forces are conceptualized and how they give rise to anxiety, that has always been a puzzle (Bowlby, 1960, p. 91).

As the opening quotes suggest, psychoanalysts have grappled with the question of anxiety from Freud's earliest formulations in classical theory to early attachment theorists such as John Bowlby writing in the 1960's. This chapter attempts to trace the arc of some of these ideas as they evolved over the first half of the twentieth century. The chapter will examine chronologically the ways that these ideas were absorbed, expanded upon, and challenged by other major theorists as psychoanalysis sought to come to an increasingly accurate, nuanced, and clinically useful theorization of anxiety. A discussion of anxiety in the work of Sigmund Freud and Anna Freud lays the foundation for an exploration of Melanie Klein's work and the role of anxiety in object relations theory. Both classical theory and object relations theory contained the seeds of attachment theory, ideas that found fuller expression in the work of the attachment theorists such as Bowlby self-psychologists like Winnicott. My hope is to capture a few of the central formulations of anxiety put forth by each of these influential theorists. I will explore the connection between their ideas in order to gain greater insight into anxiety as a phenomenon, the ways it has evolved in psychoanalytic theory, and the ways that these foundational theories inform more contemporary theorizations of anxiety, including interpersonal theory, relational theory, and trauma theory, which will be discussed in the next chapter.

As the opening quote indicates, late in his career Freud changed his conception of anxiety. At first he viewed it as a kind of discharge phenomena, arising from the pressure of repressed libido (Wachtel 2011). In the opening passage from Freud's later work "Inhibitions, Symptoms and Anxiety," he abandons this earlier economic understanding, and in his new formulation, anxiety is a signal mediated or called forth by the ego that leads to repression, the primary defense for Freud. He goes on to argue that anxiety

begins during the trauma of birth, and this experience continues in new forms after the baby enters the world:

When the infant has found out by experience that an external, perceptible object can put an end to the dangerous situation which is reminiscent of birth, the content of the danger it fears is displaced from the economic situation on to the condition which determined the situation, viz. the loss of object. It is the absence of the mother that is now the danger; and as soon as the danger arises the infant gives the signal of anxiety before the dreaded economic situation has set in. This change constitutes the first great step forward in the provision made by the infant for its self-preservation, and at the same time represents a transition from the automatic and involuntary fresh appearance of anxiety to the intentional reproduction of anxiety as a signal of danger (1926, p.137).

In this groundbreaking passage, Freud distinguishes between two main types of anxiety: automatic anxiety and signal anxiety. Automatic anxiety, such as the distress an infant feels upon birth, when he is hungry, or hears a loud noise, is the earliest, most primitive form of inescapable or “fresh” anxiety experienced almost at an organic level. For this reason, it is sometimes called annihilation anxiety since this phrase captures the degree to which it can overwhelm and terrify (Schamess and Shilkret, 2011). Through the relationship with the mother or caregiver, the infant learns that his/her anxiety can end through an external object. The danger signal that is automatic or hardwired into the baby at birth is “displaced” onto the object or caregiver. Thus, automatic anxiety becomes a signal essential for survival in relationship with the object and the loss of the

object. Here Freud lays the foundation for object relations and attachment theorists such as Klein, Winnicott, and Bowlby who would further his ideas in subsequent decades.

He also posits another striking idea that informed Klein's work and continues to inform contemporary interpersonal, trauma, and relational theory -- namely that affective states (Freud points out that we are unable to define them) are there from the beginning of life; anxiety occupies no greater or lesser significance than others, but rather serves a specific survival function that adapts to each successive stage of development. In this regard, all development whether it be understood as "normative" or "pathological" is composed of the same affective materials including anxiety. While this insight may seem self-evident, it underscores the experience near phenomenon of psychoanalysis itself, whereby a therapist can empathically enter into another person's affective experience and have an understanding of it, almost as if it were his or her own.

If anxiety is universal and is understood as an affective signal of danger originating in the ego as part of its protective and synthetic functions, how then does Freud understand the difference between an external threat, the danger posed by the loss of the object, and the internal danger posed by an instinctual impulse? Freud writes:

Anxiety is a reaction to a situation of danger. It is obviated by the ego's doing something to avoid that situation or to withdraw from it. It might be said that symptoms are created so as to avoid the generating of anxiety. But this does not go deep enough. It would be truer to say that symptoms are created so as to avoid a danger situation whose presence has been signaled by the generation of anxiety (1926, p.128).

In order to illustrate the connection between the ego, anxiety, and symptoms, Freud uses animal phobias in children. He understood animal phobias to be an expression of castration anxiety whereby fear of castration and of punishment by the super-ego becomes depersonalized or conflated with fear of something in the external world – the fear of an animal. The benefit of this symptomology is that an animal can be avoided whereas a father cannot.

While the centrality of castration anxiety in this formulation and in Freudian drive theory in general has, for most theorists, long since lost its explanatory power, Freud's observation in the above passage remains a fascinating one: namely that symptoms are an attempt by the ego to avoid a danger situation whether internal or external, and thereby are an attempt to reduce anxiety. Thus a phobia, social anxiety, generalized anxiety, or any other form of anxiety that we now diagnostically label in today's medical model as a distinct disorder with related symptomology, is, when viewed through the lens of Freudian theory, simply a signal of internal or external danger. Understood this way, anxiety is never a symptom or diagnosis on its own.

Indeed the focus on anxiety as a symptom and on its eradication through treatment ignores the underlying etiology of anxiety, and its generation and over-generation by the ego. The original instinctual impulse is given truncated expression in the form of a symptom, the ego's attempt to reduce anxiety. Furthermore, the ego, through its integrative synthetic function, tries to "prevent symptoms from remaining isolated and alien by using every possible method to bind them to itself in one way or another" (Freud, 1926, p. 98). In this process the symptom occupies what Freud called "extra-territoriality." It becomes hidden, invisible to the ego itself. The symptom only

becomes apparent if in some way repression has failed. The presence of anxiety in this case can be understood as a danger signal that must be sent over and over again to reactivate repression and or other defenses.

Anxiety and the Defenses

Anna Freud continued working within Freud's drive theory and his structural model, but became increasingly interested in the ego itself as the primary mechanism by which each individual mediates between the demands of internal and external realities. Like her father, she understood symptoms as a kind of "compromise" made by the ego through various methods of defense against instinctual demands (A. Freud, 1946). However, along with repression, Anna Freud delineated a variety of other defenses by which the ego sought to mediate between the instincts (id), the super ego, and the moral and ethical imperatives of the external world. This expanded exploration and focus on mechanisms of defense raises the question of how anxiety relates to the ego and its various defensive processes other than repression. Anna Freud argued that the ego itself had no quarrel with any of the instincts, and only utilized defense processes under pressure from the super-ego, the "mischief-maker" (A. Freud 1946, p. 59). The ego is motivated by what she called "super-ego anxiety" (A. Freud, 1946, p. 59). Yet Anna Freud also argued that while children defend against their impulses, this is not motivated by super-ego anxiety but by the threat of punishment or prohibition from adults in the outside world. She called this fear produced by external forces, "object anxiety" (A. Freud, 1946, p. 61).

In her estimation, the origin of anxiety whether it be super-ego anxiety or object anxiety made no difference at all to the ego. She writes, "the crucial point is that, whether

it be dread of the outside world or dread of the super-ego it is the anxiety which sets the defensive processes going. The symptoms which enter consciousness as a result of this process do not enable us to determine which type of anxiety in the ego has produced them” (1946, p. 61). In essence, this is a similar argument to that of her father who conflated castration anxiety with real dangers in the outside world.

According to both father and daughter, the ego and the id are still not differentiated in children, and it is only as people get older and the “the pleasure principal” is replaced by the “reality principal” (A. Freud, 1946, p.63) that the ego begins to mistrust the instincts. This transition in development is the root of anxiety in neurotic symptomology. Anna Freud writes that if “the ego feels abandoned by these protective higher powers [the super-ego and the outside world] or if the demands of the instinctual impulses become excessive, its [the ego’s] hostility to instinct is intensified to the point of anxiety ” (1946, p. 63). Whether anxiety is instinctual, super-ego, objective, or an affect related to instinct, the result is the same activation of defenses. In practice, the analyst can only determine the source of anxiety by the strength of a patient’s resistance when the analyst begins to dismantle the patient’s defenses. For example, a patient who has super-ego anxiety will experience a sense of guilt around his instincts whereas a patient who has object anxiety may experience threat from the outside world.

Anxiety is a signal that activates the ego’s defenses; however, repression is only one defense among the others with no primary place among the ego’s functions. As a result of Anna Freud’s work, projection, undoing, identification, reaction formation, denial, and other defenses became an integral part of ego psychology and the popular lexicon that carries over to the present day. Regardless of which defense is activated,

anxiety in ego psychology is not in itself a symptom, nor does the origin of anxiety necessarily predict which defense is activated by the ego since the same defense could be used in response to either an external danger or a threatening impulse. The primary area of focus for ego psychologists was identifying neurotic defenses and the unconscious instinctual impulses that had been converted by the ego into symptoms.

Melanie Klein and Object Relations Theory

The mid-century split between ego psychologists modeled after Anna Freud and Kleinians, led to the creation of distinct psychoanalytic societies, suggesting an unbridgeable rift. Yet, many of Klein's fundamental ideas are grounded in Freudian drive theory and ego defenses. However, unlike Anna Freud, who did not link particular types of anxiety with the activation of particular defenses, Klein focused on the ways that drives activate certain defenses that operate as an integral part of early development. Thus, it is easy to see how the two theoretical approaches seemed incompatible, or even diametrically opposed, even though they are both firmly grounded in Freudian drive theory.

Klein accepts Freud's theorization of the libidinal and aggressive drives that corresponds to the life and death instincts. However, for Klein, anxiety was not just automatic or a signal generated by the ego for survival; rather anxiety in the form of the "death instinct" and "annihilation anxiety" are present from the beginning of life and remain the core affective experience undergirding the rest of human development. She writes in the opening sentences of her later work:

I have for many years held the view that the working of the death instinct within gives rise to the fear of annihilation and that this is the primary

cause for persecutory anxiety. It would appear that the pain and discomfort he [the infant] has suffered, as well as the loss of the intra-uterine state, are felt by him as an attack by hostile forces, i.e. as persecution. Persecution anxiety, therefore, enters from the beginning into his relation to objects in so far as he is exposed to privations (Klein, 1952, p. 61).

Here, anxiety is no longer a signal of danger, but exists in relation to objects and is rooted in the experience of persecution in the form a hostile attack. The infant lives in a phantasmagoric world where he or she can be annihilated at any moment. This increase in persecutory anxiety heightens his or her own aggressive and destructive impulses. As Ruth Stein (1990) argues in her analysis of Klein's work in the 30's, sadism takes the form of fear of attack, which increases the child's sadistic impulses. However, these impulses are not channeled into psychosexual stages as they are for Freud, but become attached to objects in the child's life that are both continually introjected (internalized) and projected onto (expelled or externalized), setting in motion a circular pattern within relationships. It could be argued that these defensive operations and the degree to which they protect the infant's fragile ego from their own aggressive impulses lays the foundation for dangerous relational cycles that continue into adulthood, a formulation that bears a close resonance with Freud's concept of the repetition compulsion in relationships. For Klein, object relations in infancy are directly connected to the same affects and defensive processes in all people, and these underlie, more so than the psychosexual stages, the affects and ambivalence that structure the individual psyche in relationship to others. The circular nature with which aggression generates anxiety and anxiety generates aggression, internal impulses and external objects are projected and

then introjected, then expelled again through projective identification, is emblematic of the fluid and circular logic which structures Klein's theory of how humans develop in relationship; opposites continually exists alongside each other either isolated or split off from each other or integrated by the ego to a greater or lesser extent.

This fundamental ambivalence between opposites extends in Klein's work to the life long struggle between antithetical affects. She writes: "The recurrent experiences of gratification and frustration are powerful stimuli for libidinal and destructive impulses, for love and hatred. As a result, the breast inasmuch as it is gratifying is loved and felt to be 'good'; in so far as it is a source of frustration, hated and felt to be 'bad' (Klein, 1952, p. 62).

The infant's ego is not developed enough to withstand annihilation anxiety, or to realize that gratification and frustration, good and bad, love and hate exist in the same object (the breast). Therefore, profound persecutory anxiety leads the infant to isolate these affects through splitting in the earliest stages of development. In other words, the bad breast and good breast cannot be allowed to exist in the same object or caregiver, just as those same affects cannot exist simultaneously in the infant; the infant cannot destroy the very object that gives it life and sustenance or believe that that same object is out to destroy him or her if he or she is to accept, devour, and introject the good object. All of this also requires the defenses of denial and idealization in order to keep the good object completely separate from the existence of the bad. For Klein, the defense mechanisms of isolation, splitting, denial, and idealization are a fundamental and unchanging process in the earliest stage of infant development. She labeled this process the paranoid-schizoid position.

The infant's experience of privation and gratification are indistinguishable from their own fantasies and omnipotence and are constantly projected and introjected in self-reinforcing patterns. The universal nature of this affective process rooted in the death instinct and persecution anxiety form the basis for both "normative" and "pathological" development; the seed of both are present and possible in all people. Again this highlights the experience near process of psychoanalysis: the ability of one person to empathize with and enter the cognitive and affective experience of another even if the other is understood as suffering from a "disorder" such as psychosis.

While Klein (1952) writes of the good breast and bad breast to capture the infant's dependency and the unintegrated schizoid nature of this stage, the relationship the infant has to the mother's breast extends to the mother's bodily presence in all its forms. It could be stated that the mother's whole body is gradually introjected as an object, which also implies the burgeoning possibility of greater psychic integration. Indeed for Klein, this is what emerges out of early infancy as the good and bad objects gradually become attached to the same caregiver.

The infant is in a constant process of establishing their object relationships. As the infant attaches libidinal love-feelings to the object, projects this outward, and then reintrojects these feelings in relationship to the caregiver, persecutory anxiety produced by external hardship and aggressive impulses is counterbalanced by loving or good object relations. Klein writes:

. . . the relation to both the internal and external world improves simultaneously and the ego gains in strength and integration. Progress in integration . . . depends on love-impulses predominating over destructive

impulses, and leads to transitory states in which the ego synthesizes feelings of love and destructive impulses towards one object (first the mother's breast) (1952, p. 65).

This early attempt by the ego at synthesis leads to what Klein calls the depressive position, in which primitive defenses such as isolation, splitting, and denial give way to greater synthesis and integration. Inherent in this process are the generation of qualitatively different affective states. Klein writes:

All these processes of integration and synthesis cause the conflict between love and hatred to come out in full force. The ensuing depressive anxiety and feeling of guilt alter not only in quantity but in quality. Ambivalence is now experienced predominantly toward a complete object. Love and hatred have come much closer together and the 'good' and 'bad' breast, 'good' and 'bad' mother cannot be kept as widely separated as in the earlier stage (1952, p. 72).

The infant's destructive impulses are now experienced as a threat to the good object, and Klein describes a complex process of guilt, inhibition of destructive impulses, and a kind of mourning for the loss of the all good object that is inherent to the growing awareness of what Klein calls "increasingly poignant psychic reality" (1952, p. 73). For Klein, development and human relationships in general are shaped by the ambivalent affective states that characterize the depressive position. She writes, "The anxiety relating to the internalized mother who is felt to be injured, suffering, in danger of being annihilated, or already annihilated and lost forever, leads to stronger identification with the injured object" (1952, p. 73). Now the ego's primary job is to reduce the depressive anxiety

generated by the integration of ambivalent affects. Over time, the infant's conception of his or her parents comes closer to reality. The capacity to manage depressive anxiety is directly related to the degree to which he or she was able to take in good objects in the earlier phase.

In order to capture infant development, a phase of life that is ultimately inaccessible to language, and is therefore on some level unknowable, Klein relies on abstract language and theories to enter the realm of fantasy in ways that seem to resonate with observed and lived experience. Her insistence on an infant full of destructive affects who is fundamentally born into a psychotic state that is the foundation of development can seem like a dark and somewhat fantastic conjecture depending on the reader. Yet what Klein is really arguing in very sophisticated terms is what Ruth Stein calls (1990) a theory of affect, a way to explain the complex mental processes that characterize both 'normative' and 'pathological' development. As Mitchell and Greenberg (1983) argue, the drives for Klein are really affects that develop and exist in relationship. Put simply, the caregiving environment either successfully reduces anxiety in its various forms or increases it through a dialectical process of expulsion, absorption, and reabsorption of external and internal objects, and this dynamic profoundly influences the developing ego. Along with her focus on affect and the drives, Klein's developing infant is also clearly shaped by the quality of the relationship with the mother. In this regard, her work contains many of the seeds of attachment theory.

Winnicott, Bowlby and Attachment Theory

Although Klein argued that persecution anxiety could be reduced through the loving objects, infancy for Klein was fundamentally fraught with profound anxieties and

ambivalence. By contrast, for Winnicott, the mother-child relationship was central to all aspects of development and the quality of this relationship and not the drives, played the most formative role in shaping development. He captured the nature of the mother-child relationship with the concept of the “holding environment.” Flanagan aptly describes the holding environment as “the capacity of the mother to create the world in such a way for the baby that she feels held, safe, and protected from the dangers without and protected as well from the dangers of emotions within” (2011, p. 127).

Winnicott distilled some of the complex object relations in Klein’s phantasmagoric theorization into a more streamlined and accessible concept that is now common in psychoanalytic theory as well as many parenting books. While parents may not take reassurance in understanding their newborn as psychotic and fearing annihilation, they can certainly embrace creating a loving safe environment in which the child is protected from internal and external dangers and anxieties. No doubt this helps explain why the holding environment has become a familiar concept and the paranoid-schizoid position, regardless of its explanatory resonance, is not.

While Klein and Winnicott understood anxiety in some similar ways, they conceptualized it using very different language. Just as Klein postulated that early object relationships create the intrapsychic and relational processes that inform later pathologies and relational dangers, Winnicott argued that “insanity” was grounded in what were universal phenomena (1963); every person had the empathic capacity to understand the “insane.” In his paper “Fear of Breakdown,” Winnicott (1963) replaces the concept of annihilation anxiety with a common phenomenon he observes in many psychotic patients – what he calls the “fear of breakdown.” By breakdown, Winnicott means a failure of a

defense to protect ego organization rooted in early development when the infant is entirely dependent on and undifferentiated from the mother. In Kleinian terms, this might be understood as a failure of defensive processes to reduce annihilation and persecution anxiety. Rather than using the concept of anxiety to explain early development, Winnicott states that anxiety is not a strong enough word to describe what he calls “primitive agonies” (1963, p. 89). Indeed for Winnicott (1963), anxiety did not capture the agonizing fear that lead to early ego defenses, and psychotic illness was itself a kind of defense against these.

Thus, the fear of breakdown that he observed in many of his patients was not the fear of something new, or something that was about to happen, but the fear of psychic deaths that had already occurred for the individual in early childhood as their ego organization was forming. Winnicott writes, “it is the fear of the original agony which caused the defence organization which the patient displays as an illness syndrome” (1963, p. 90). Thus, it could be said that the patient does not have annihilation anxiety; rather, the patient has already been annihilated, and what he or she fears are the psychic deaths he has previously experienced which remain hidden in his unconscious. Like the infant ego in Klein’s paranoid schizoid position, Winnicott argues that by unconscious he means that “ego integration is not able to encompass something. The ego is too immature to gather all the phenomenon into the area of personal omnipotence” (1963, p. 91). The early experience remains hidden or isolated and split, precisely because the ego does not have the capacity to integrate or encompass it. Therefore, the only way for the patient to end his fear of breakdown is to actually have a breakdown or to “gather it into its own present time experience and into omnipotent control (assuming the auxiliary ego-

supporting function of the mother [analyst]” (Winnicott, 1963, p. 91). The ego can then begin to integrate what the immature ego was unable to handle. In contrast to Klein, Winnicott’s psychic deaths are not rooted in the drives, but are primarily created by “failures in the facilitating environment” (1963, p. 91) that impinge on the individual in ways that overwhelm his immature ego. Here Winnicott is implying the concepts that underlie attachment, for what he is really positing is a failure in the holding environment that disrupts attachment.

For Bowlby, such a failure in the caretaking environment is generated by separation anxiety, the cornerstone of Bowlby’s theorization of anxiety and its role in normative and pathogenic development. Like the object relations theorists, Bowlby continued to view anxiety in a relational context. However, for Bowlby, anxiety was not just a failure of the holding environment; rather, he understood anxiety as an essential survival instinct shaping the infant-mother relationship. In other words, separation anxiety is central to survival since it impels the infant to seek its mother for survival at the same time that it gives rise to the instinct to flee from a perceived threat. Thus, anxiety has a highly adaptive function within Bowlby’s attachment framework.

In his article “Separation Anxiety,” Bowlby (1960) grounded his theoretical framework in his observations of children ages 15 to 30 months old who were admitted to the hospital, separated from their mothers, and cared for by a changing series of nurses. Over time, these children all displayed a similar set of responses, starting with protest (crying and upset), then grief and mourning (withdrawal) and finally detachment (a turning away from human relationships). The first phase in which the child cries for its mother demonstrates separation anxiety, the second, mourning, and the third, defense.

While Freud was aware of all of these processes, Bowlby argues that Freud discovered them in the reverse chronology to the way they actually occur (1960). This made it difficult for Freud to theorize their connection to each other until the end of his career when he began to put the pieces together in “Inhibitions, Symptoms and Anxiety” (1926). According to Bowlby, in this late work, Freud finally realized the central etiological role of separation anxiety in development.

In “Separation Anxiety” (1960), Bowlby summarizes six primary theories of anxiety including Freud’s and Klein’s and concludes that both of these theories revolve around attachment. However, Bowlby rejects Klein’s notions of depressive and persecutory anxiety as well as Freud’s notion of signal anxiety, and asserts that the idea of “primary anxiety” has the most explanatory power. As Bowlby’s observations of the infants in the hospital bore out, “the child is bound to his mother by a number of instinctual response systems, each of which is primary, and which together have high survival value” (Bowlby, 1960, p. 92). In other words, when the isolated child cries, this activates clinging and following in order to motivate closeness to the mother. “Pending this outcome, it is suggested, his subjective experience is that of primary anxiety; when he is close to her it is one of comfort” (Bowlby, 1960, p. 92). Thus, for Bowlby, primary anxiety and its attendant instinctual response system is a physiologically-based behavior pattern bred into the organism through evolution that allows for the attachment between mother and infant to occur.

Bowlby (1960) further argues that once activated, if the instinctual response meets some kinds of blockage and cannot reach its termination point, then anxiety is generated. Thus, if the baby in the hospital cries for its mother, but she does not come, this generates

separation anxiety and the co-occurring psychological and physiological changes in the infant. If separation anxiety becomes too great and there is no termination point, this has a particularly “pathogenic” effect on the infant since he or she is entirely dependent at this phase of life (Bowlby, 1960). Likewise separation engenders fear which is connected to the fight or flight response. Thus, separation anxiety is “doubly alarming” (Bowlby, 1960, p. 104) for the infant, and this is another reason why he posits that “. . . separation anxiety is the inescapable corollary of attachment behavior” (1960, p. 102). If anxiety is inextricable from attachment -- the foundation of human relationships -- can anxiety ever be a symptom treated independently of other dynamic processes, and can it ever be eradicated?

In classical theory, object relations, and attachment theory, anxiety is inextricably bound to human development and survival, and can never be treated as an independent phenomenon that exists outside of relationships. In recent years, multiple studies have established a strong correlation between the nature and quality of early and adult attachment relationships and the susceptibility to and prevalence of mental health disorders. Thus, as a disorder, anxiety can better be understood within a psychoanalytic frame as a disturbance in attachment. Viewed through the lens of theorists such as Bowlby and Winnicott, failures in the caretaking environment lead to psychological and physiological responses that inform relational patterns and intrapsychic processes that are now classified as disorders.

The relational focus of attachment theory with its roots in classical theory and object relations laid the foundation for the interpersonal and relational theorists who extend these ideas into an increasingly nuanced and complex understanding of psychic

processes and how they develop both inside and outside the therapeutic relationship.

Several of these theorists, including Harry Stack-Sullivan, Stephen Mitchell and Phil Bromberg, will be discussed in the next chapter. Ideas about the role of anxiety in the therapeutic relationship itself as well as notions of self and how that relates to attachment and anxiety will be further explored as well.

CHAPTER IV

The Emergence of Relational Theory and Anxiety in a Relational Context

Introduction

This chapter will continue to examine theoretical formulations of anxiety and the ways that they have been integrated through relational theory. Paralleling the mid-20th century development of British object relations and attachment theory, in the United States, Harry Stack Sullivan developed his theory of interpersonal psychiatry. This chapter will begin with an examination of some of Sullivan's central ideas, particularly concerning the function of anxiety in relationships, a central facet of his theorization. The chapter will shift focus to contemporary relational theory as outlined by Stephen Mitchell, and will examine the ways that Mitchell integrates interpersonal theory, object relations, and attachment theories creating what is now thought of as relational theory. Finally the chapter will explore Phil Bromberg's theorization of trauma and dissociated self-states in conjunction with some of the foundational ideas about trauma articulated by Judith Herman. Some connections between these theorists and earlier formulations of anxiety will be explored as well as the question of how anxiety itself becomes part of the process of therapeutic change within Bromberg's relational theorization of disassociation and trauma.

Interpersonal Theory

. . . .The need for interpersonal security might be said to be the need to be rid of anxiety. But anxiety is not manageable: It comes by induction from another person; the infants capacity for manipulating another person is confined at the very start, to the sole capacity to call out tenderness by manifesting needs; and the person who would respond to manifest need in the situation in which the infant is anxious is relatively incapable of that response because it is the parental anxiety which induces the infant's anxiety – and . . . anxiety always interferes with any other tensions with which it coincides. Therefore, there is, from the very earliest evidence of the empathic linkage, this peculiar distinction that anxiety is not manageable (Sullivan, 1953, p.43).

Harry Stack Sullivan, one of the originators of interpersonal psychology, posited anxiety as the central force mediating relationships. Unlike Freud and early object relations theorists such as Klein who understood forms of anxiety primarily as innate intra-psychic processes influenced by relationships with caregivers and the outside world, Sullivan understood anxiety entirely as a manifestation of interpersonal relationships. As Greenberg and Mitchell argue, Sullivan's interpersonal focus marks a paradigm shift from a drive model and structural theory to a relational focus (1983, p.12). Unlike Freud who understood development and human motivation as a manifestation of the drives, for Sullivan human behavior is motivated by needs, satisfaction, and security within relationships. Sullivan writes,

whether one is getting more or less anxious is in a large sense the basic influence which determines interpersonal relations – that is, it is not the motor, it does not call interpersonal relations into being, but it more or less directs the course of their development (1953, p. 160).

For Sullivan, structural models of the mind, whether they be through the lens of Freudian drive theory or object relations theory, were at best an imagined and static rendering of what he saw as a constantly evolving set of dynamic processes in which the individual psyche took shape and constantly adapted within an interpersonal field.

Similarly to attachment theorists like Bowlby and self-psychologists like Winnicott, Sullivan focused on the role of caretakers and the caretaking environment. However, for Sullivan, anxiety only exists in the interpersonal field between individuals and is generated by the caretaker; anxiety did not serve an adaptive function, it was not a signal, a primal instinct or a fear of a previous psychic death; rather anxiety is an affect passed on to children by their caretakers that serves little function other than to interfere in the establishment of a pattern of mutually satisfying relationships. According to Sullivan, the infant's earliest relation to caregivers is one of need that generates "tenderness" (Sullivan, 1953, p.40) in a caregiver (what he termed the mothering one) and the desire to fulfill these needs. Thus, relationships from the outset revolve around the mutual satisfaction of needs. However, if the caretaker does not meet these needs, or the caretaker experiences anxiety with regard to these needs, this is passed from caretaker to infant through "empathic linkage" (Sullivan, 1953, p. 41) and a process of emotional contagion (Sullivan, 1953, p. 53): a dialectical model in which caregiver anxiety is transmitted to the infant, and the resulting anxiety in the infant further exacerbates

caregiver anxiety creating an affective state that is a closed system, with no escape, and as the opening quote states, no mechanism for management.

The experience of anxiety in relationships over the course of development is central to the formation of what Sullivan termed the “self-system” (1953, p.109) in adults, shaped by each individual’s efforts to avoid or to reduce anxiety. Over time, children adapt their behavior in response to caregiver anxiety, avoiding the behaviors that exacerbate anxiety and engaging in the ones that reduce it. This process shapes each person’s self- system, grounded within a set of internalized personifications that take shape in relationship to caregivers. Sullivan broke these personifications down to three categories: “Good me,” is the child’s experience of self when their needs are satisfied by caregiver tenderness and reward. “Bad me,” is the self personification based on experiences along an “anxiety gradient” in relationship with the “mothering one,” who reinforces behavior and self experience through forms of mutual acceptance and disapproval. “Not me” occurs through the experience of intense anxiety in relation to caregivers and is the basis in Sullivan’s theorization of serious mental disorders such as schizophrenia (Sullivan, 1953, p.162). Intense anxiety completely obscures the connection between affective experience and reality, and the person is left in a primitive state of dread in which affective states cannot be integrated with lived experience.

These personifications based on early experiences with caregivers (not just the mother) form the self-system and give rise in adults to what Sullivan terms “security operations” (Sullivan, 1953, p.169). Security operations are the complex processes and formulations of self that help each individual to minimize anxiety through an illusory sense of self that allows each person to feel powerful, safe and secure (Mitchell and

Black, 1995, p. 84). In this regard, security operations are based on a sense of self that operates outside of conscious awareness, which obscures the original early experiences in relationships that generated anxiety. Thus, security operations create distortions; past relational patterns contained in the self-system limit experience and shape current relationships in ways that prevent the mutual satisfaction of needs. The invisible or unconscious nature of these operations and how they confine and distort relational patterns is, for Sullivan, at the heart of the analyst's work with every patient.

Further breaking with Freudian theory and early objects relations theorists such as Klein, the analyst in Sullivan's interpersonal theorization (1953, p. 13) is not a blank screen, an object, or a site of projective identification, but is part of the interpersonal field that shapes the self-system from moment to moment. The patient inevitably enacts security operations rooted in past relationships with the analyst, a conception similar in some ways to Freud's idea of transference. However, for Sullivan the analyst was not a passive recipient of transference but what he called a "participant observer" in the relational field.

The clinician's careful attunement to what Sullivan termed the anxiety-empathy gradient in the relational field (1953, p.160) creates a secure enough environment for the patient to experience his or her vulnerabilities in relationships, and the ways that relational patterns designed to avoid or reduce anxiety in the short term, undermine a greater range of satisfying relational experiences and mutuality in the long run. It is the analyst's job to identify the patient's security operations and underlying self-system in order to understand the source of anxiety in relationships. The aim is to help the patient identify self-limiting behaviors and find new more satisfying ways of relating. Thus,

while the analyst is a participant in the relational field, the analyst, as the word “observer” implies, always remains in some sense outside the enactment, clarifying the nature of the patient’s security operations from within their professional role. Mitchell and Black write:

Sullivan did not regard it as helpful for the analyst to get deeply personally involved with the patient. The analyst was an expert at interpersonal relations, and her expert status would keep her from getting drawn into pathological integrations. . . . The competent analyst would have no strong or turbulent feelings for the patient (1995, p. 79).

Within this framework, the analyst is a participant in the relational field, but only insofar as he or she is ultimately an expert guide helping the client through the maze of their self-system and security operations. The analyst helps the patient find their way out of an invisible, closed, anxiety driven relational system into more open terrain where the patient can relate more freely within a broader, less anxious and more mutually satisfying interpersonal landscape.

Relational Theory

The paradigm shift that took place in the development of interpersonal theory, object relations, and attachment theories moving from the intra-psychic and a drive model, to an understanding of the mind as taking shape and only having meaning within a relational context, profoundly altered the theory and practice of psychoanalysis in recent decades. The increasing dyadic emphasis of British object relations theories developed by Klein, and Fairbairn signaled a shift away from classical theorizations that were almost exclusively grounded in drive-based intrapsychic processes. Likewise, the emergence of

attachment theories in England by theorists such as Bowlby, Ainsworth, and Winnicott marked a shift towards an increasingly dyadic view of development from infancy onwards.

Paralleling these dyadic developments among English object relations theorists, Sullivan's interpersonal ideas of self as a set of illusory dynamic constructions formed to manage anxiety in relationships (1953), also prefigured the postmodern paradigm shift to notions of a decentered reality in which all "truth" is conditional and constructed. Sullivan abhorred static psychiatric claims to authority and its obfuscating language of mental illness that shaped the treatment of schizophrenics that he witnessed early in his career. He was equally uncomfortable with the presumptions of structural theory and object relations as offering "imagined furnishings" of the unconscious (Mitchell and Greenberg, 1983, p. 104). According to Sullivan, all of these theories utilized language that suggested certainties where none existed. Despite his attempts to avoid the pitfalls of theorizing phenomenon that fundamentally defied language, Sullivan's entire system of thought is based on a very concrete assumption or truth: namely that anxiety is the primary affect shaping human development and social interaction. In some respects, like Freud's focus on repression or the super-ego within the drive model, the management of anxiety vis-a-vis the self system has an equally axiomatic and perhaps reductive place within Sullivan's interpersonal formulation.

The imperative to legitimate their ideas -- for Freud to make psychoanalysis scientific, and for Sullivan to do the same with interpersonal psychiatry -- is one way to understand the focused emphasis of both of these early theorizations. Viewed within the social, historical, and personal forces of the times in which they lived, both men

attempted to delineate clear schematic, scientific explanations of what are intangible and elusive phenomenon. Indeed in Sullivan's 1948 paper titled "The Meaning of Anxiety in Psychiatry and Life," he supplies drawings that render schematic representations of the personality and the ways that anxiety shapes the relational field. Sullivan writes, "scientific psychiatry has to be defined as the study of interpersonal relations" (1953, p. 368), a statement that now appears to relational theorists as almost paradoxical in its aims.

While the pressure for scientific and empirical evidence as the basis for theory and treatment practices is hardly a relic of the past (as the current dominance of the "evidence based" medical model makes clear), the relational turn of psychoanalytic theory in recent decades embraces an increasingly decentered understanding of human experience, attempting to integrate the claims and ideas of seemingly incompatible or closed theoretical systems. Stephen Mitchell, in his book *Relational Concepts in Psychoanalysis An Integration* (1988), explicitly makes this his primary project. Mitchell charts the paradigm shift from the one-person drive theory model to the increasingly two person models beginning with attachment theorists such as Bowlby and object relations theorists such as Fairbairn, and self-psychologists such as Winnicott. He integrates these ideas with Harry Stack Sullivan and subsequent interpersonal and relational theorists. Mitchell understands the monadic emphasis of drive theory as incompatible with relational views in which the mind is primarily viewed as "interactive" (1988, p. 60). For this reason, he does not attempt to integrate classical drive theory with relational theory, but sees it as a "derivative of the interactional field" (Mitchell, 1988, p.61). Mitchell writes:

Freud's system, like all intellectual constructs, has inevitably been outgrown, but the singularity of his achievement became the model followed by his successors, who tend to present their contributions not as partial replacements or solutions to particular features which Freud addressed, but as alternative, comprehensive systems. Consequently, they overlook the similarity and compatibility of their efforts and call for exclusive loyalty, which is neither compelling nor necessary (1988, p.7).

This stated goal of integration frames Mitchell's project, and throughout his book, he finds ways to connect interpersonal theory to various object relations theories, as well as pointing out the differences. Mitchell writes:

I do not believe that interpersonal interactions are merely an "enactment" of a more psychologically fundamental world of internal object relations or "representations"; nor do I believe that subjective experience is merely a recording of actual interpersonal interactions. *The most useful way to view psychological reality is as operating within a relational matrix which encompasses both intrapsychic and interpersonal realms* (1988, p.9).

Where then does his project of integration leave the concept of, and phenomenological experience of, anxiety within the relational matrix? Although Mitchell never states this outright, the decentered nature of relational theory makes the prioritization of one affective state, or even a focus on its definition and treatment irrelevant, since anxiety cannot be defined as a phenomenon outside the relational matrix. However, it is useful here to look at some of the ways that he integrates different theoretical approaches already discussed in this thesis in order to understand how these

formulations of anxiety inform relational theory. In this regard, it can also be argued that relational concepts are less a theory in their own right, and more an integration of previous ideas, an overarching approach to psychoanalytic theory and practice that encompasses to a greater extent, the full complexity of psychological experience.

Mitchell begins his theoretical integration with a discussion of frameworks that he labels “relational by design” (1988, p. 21) including Bowlby’s attachment theory which posits the infant’s relationship with the mother as a survival mechanism that is genetically encoded. As noted in the previous chapter, separation anxiety was, in Bowlby’s model, the corollary of attachment behavior. In this respect, attachment is a primary instinct that does not rely on relatedness from the outset, and as such, is consistent with Freudian ideas of drive that are derivative of Darwinian theory. However, Bowlby’s attachment theory also gestures toward the dyadic nature of infant development that sees interaction as an end in its own right, not a means of “gratifying or channeling something else” (Mitchell, 1988, p. 24) as it is in drive theory.

Mitchell (1988) further points out that current infancy research increasingly suggests that rather than being an instinct that predates perception, attachment is from the outset very much connected to the experience in relationship with a particular person, and that the infant perceives far more from very early on than was previously understood. Put simply, infants are complexly relational from the outset and not just governed by primary instincts. Bowlby’s emphasis on separation anxiety, the cornerstone of his attachment theory that distinguished him from Freud’s idea of the object, can now be understood within a relational context as the attachment to a particular person or people and all the complexity this entails. Within this framework, separation anxiety is only one

phenomenological experience amidst the multiplicity of relational experiences that defines infants and primary caregivers.

A similar analysis also clarifies Sullivan's conception of anxiety in the interpersonal field. Sullivan's focus on essential human needs, the satisfaction of these needs, and the ways this connects infants and caretakers, locates him, along with Bowlby, in Mitchell's relational by design grouping. While Sullivan abandons Freud's reliance on drives as a primary motivation in human psychology, he replaces this with the interpersonal experience of the anxiety gradient; the need to avoid or reduce anxiety in the relational field. Ideally, relationships that are solely mutually satisfying without the intrusion of anxiety are possible, but the empathic linkage complicates this ideal, and creates what Sullivan called "problems with living" (1953. P.4) Thus, even as Sullivan argues that people only develop in relation to others and that notions of the self are in fact systematized illusions based on past relational patterns, the experience of anxiety remains the dominant affect shaping relationships. Relational design for Sullivan implies an opposite design flaw in the form of anxiety.

Mitchell labels his next grouping, "relational by intent" (1988, p. 26), and focuses his attention on Fairbairn's explanation for individual attachment to bad objects as a way to explain what Freud called the repetition compulsion of destructive or masochistic relationships and behaviors. Fairbairn argued that humans hold onto bad objects as an attempt to remain connected to their caregivers in the only ways that were available to them as infants and children (Mitchell, 1988). Mitchell writes that:

Fairbairn regards object seeking as innate, and his approach is closely related to Bowlby's notion of attachment. Bowlby portrays attachment as

an automatic mechanism, the product of instinctive, reflexive behavioral subsystems. . . . Fairbairn adds a consideration of intention and emotional presence or absence and thereby highlights the longing, the hunger for contact and connection, that propels human relationships (1988, p. 28).

Mitchell argues that this complements Sullivan's idea of relational by design in which the child's innate needs, and not so much his intent, draw him or her into relatedness with others. Similarly to Sullivan, Fairbairn's notion of loss of connection to bad internal objects and the fear of being alone in the world can also be understood as a way that anxiety experienced in past relationships generates the repetition of destructive or pathological relational patterns in order to preserve existing patterns of connection with primary caregivers.

Mitchell also understands Klein in a relational context that he includes as relational by intent. Although Klein firmly grounded infant development in the drives and annihilation anxiety, persecution anxiety, and the anxiety and guilt produced by the ambivalence of the depressive position, Mitchell (1988) argues that Klein's theorization can be read outside the realm of fantasy and drive. He translates Klein's idea of reparation and gratitude versus envious spoiling and manic triumph into a more relational context that is similar in thrust to Fairbairn. He writes:

The urge for reparation can be understood as emerging not as a reaction to fantasized damage, but to the other's real sufferings and characteristic pathology. . . . Envious spoiling can be understood not as an excess of constitutional aggression, but as an attempt to escape from the painful

position of loving and desiring a largely absent or damaged parent, or, particularly, an inconsistent parent (Mitchell, 1988, p. 29).

Notwithstanding Klein's fantasy framework of powerful affects attached to objects, Klein's infant develops in relationship with real caregivers who either reduce anxiety and the aggressive drives through loving object experiences or who heighten the defenses and destructive affects that underlie both the paranoid schizoid position and the depressive position. The emphasis of Klein's primitive anxieties and powerful affects are, from a relational perspective, shaped by distinct primary relationships.

Mitchell's last theoretical grouping within the relational matrix, he labels "relational by implication" (1988, p. 29). He includes Winnicott and Kohut in this category and argues that the development of a sense of self that is central to both these theorists occurs in relationship to others, particularly primary caregivers. Winnicott's almost exclusive focus on the holding environment created by the mother is the necessity for the emergence of a "solid sense of self as the central achievement of normal early development The capacity to experience and hold onto a sense of one's own being as real depends on the mother's doing so first, mirroring back to the child who he is and what he is like" (Mitchell, 1988, p.31). Although Mitchell does not address Winnicott's fear of breakdown as a central experience in mental illness, past experience of psychic death in relationships that underlies this fear suggests a fear of fragmentation in which the infant's or child's sense of self is damaged through an inadequate or destructive caretaking environment.

Sullivan's self-system comprised of illusory personifications of self is strikingly similar to Winnicott's notion of the false self that takes shape in negating and pathogenic

caretaking environments. It could also be argued that Winnicott's fear of breakdown bears a strong theoretical resonance with the splitting that occurs in Klein's paranoid schizoid position and the ways that pathogenic care heightens annihilation anxiety. Psychic deaths that occurred in infancy and early childhood are covered over by a false self, or (understood in the multiplicity of the relational context) false selves are a product of experiences of intense anxiety in relationships that Sullivan labels with the self-personification of "not me" (1953, p.161). While these ways of connecting theoretical constructions of anxiety and its role in psychological development are mine not Mitchell's, the integration of these conceptions of anxiety that are central to what are usually framed as complete theoretical systems that must stand alone, is only made possible by the decentered orientation of relational theory.

Within the relational matrix, the phenomenon of anxiety and its various theoretical formulations are not necessarily incompatible. While there is no attempt in Mitchell's book to define anxiety or to pin down its role in relationships and the functioning of the human mind, the word "anxiety" and its implied meanings grounded in previous theoretical formulations, remain an important conceptual and linguistic referent in Mitchell's discussions. In his description of the way that each person is embedded in his or her relational matrix, Mitchell writes:

The prolonged condition of childhood dependency makes the discovery and forging of reliable points of connection not just an emotional necessity but an apparent condition for physical survival. . . . One's condition can never be taken for granted. One is always in some ultimate sense at the mercy of adults. The parents can never be purely facilitative, simply

allowing the child to find his or her own path. The anxieties inherent in childhood make it necessary for the child to employ the parents as specific points of reference, their idiosyncrasies becoming anchors for all subsequent joinings (1988, p. 276).

A closer reading of the language and conceptual content in this passage illustrates the ways that relational theory integrates previous theories to create a new paradigm. Indeed what is most striking about this passage is the range of ideas that it draws upon. The reference to “physical survival” is suggestive of the Darwinian primary instincts that undergird Bowlby’s attachment framework. “The prolonged condition of childhood dependency” implies the fundamental needs that create mutuality between infants and caregivers in Sullivan’s interpersonal theory. The notion that parents can never be “purely facilitative” references Winnicott’s holding environment as the condition for the formation of a sense of self while “[t]he anxieties inherent in childhood,” undermine the notion that such a preformed environment can exist. Yet this phrase also reaches still farther back to Freud’s idea of signal anxiety and its ubiquitous role in development, and likewise resonates with the profound anxieties that structure Klein’s stages of childhood development. Finally the word “idiosyncratic” in the last sentence of the paragraph, locates individual human experience outside the reach of any theory, stressing instead the unique relational matrix that shapes every person. While theoretical orthodoxy and any notion of scientific accuracy are discarded by the end of the paragraph, what emerges is a much more complex vision of human experience and the ways that individual psychology emerges and finds expression in relationships.

At the end of his project of integration, the final chapter of Mitchell's book focuses on the analytic process itself and how change is facilitated through the therapeutic action within the relational matrix between analyst and patient. Mitchell (1988) points out that every theoretical stance generates a different set of questions and narratives, which influence the nature of the analytic action. However, in a relational approach, the analyst is not positioned, as in classical theory, outside the relational matrix. Nor is he a participant observer acting as an expert guide through anxiety, or offering a needed corrective of what was missed or damaged in childhood, as is the case in interpersonal theory and self psychology. Instead the analyst works from:

within the structures and strictures of the repetitive configurations of the analysand's relational matrix. The struggle to find his way out, the collaborative effort of analyst and analysand to observe and understand these configurations and to discover other channels through which to engage each other, is the crucible of analytic change" (Mitchell, 1988, p. 292).

The nature of being "embedded" is for the analyst " 'relatively uncontrolled at the experiential level' " (1988, p. 293) and in this respect is not fundamentally theory driven. This is not a license for the analyst to do whatever they want in session, but it implies that the analysand's experience in relationship with the analyst is itself the primary action for change; interpretation, affect, language, tone, and non verbal expression are all integral parts of this process.

The Relational Matrix, Dissociation, and Multiple Self-States

The contemporary relational psychoanalytic theorist, Phil Bromberg, extended both Sullivan's and Winnicott's ideas to encompass a greater range of expression than good, bad, and not me or a false self. Bromberg locates the idea for multiple self-states in Winnicott's introduction to classical psychoanalysis of the idea of the decentered self (1998). Expanding upon Sullivan's early formulations of a decentered self (good, bad and not me), Bromberg writes that:

unless the concept of self-dynamism is revived and synthesized with a developmental evolution of "personifications" which is broader in scope, it will be extremely difficult to develop interpersonal theory beyond the point of seeing the "self" simply as an "anxiety-gating" mechanism with only ambiguous theoretical linkage to how it undergoes representational change in psychoanalysis. (1998, p. 40)

In this passage, Bromberg challenges Sullivan's idea that personifications take shape solely in response to anxiety in relationship. Here Bromberg alludes to what in his later work he calls dissociated self-states. For Bromberg, self-representation cannot be reduced to a few categories such as good me, bad me or not me, nor could the self's only function be the management of anxiety in past and current relationships including the analytic one. Instead Bromberg argues that each person is composed of multiple self-states.

Dissociation serves an adaptive or healthy function enabling their coexistence, yet allowing one or the other to come to the fore in order to enhance the ego's integrating function of the infinite variety of stimuli presented by daily existence. In this formulation, dissociation, much like Bowlby's conception of attachment, is an adaptive function

necessary for survival; it only becomes a pathogenic process when self states are fragmented to the degree that one is completely unknowable or lacks any cohesion with the others undermining “an overarching cognitive and experiential state felt as ‘me’” (Bromberg, 1998, p. 273).

The experience of a unitary coherent self is also a necessary “adaptive illusion” created by the ability to dissociate self-states (Bromberg, 1998, p.273). It is only when this “adaptive illusion of unity is traumatically threatened with unavoidable, precipitous disruption that it becomes, in itself a liability because it is in jeopardy of being overwhelmed by input it cannot process. . . .” (Bromberg, 1998, p.273). Thus, paradoxically for Bromberg, “when the illusion of unity is too dangerous to be maintained there is then a return to the simplicity of dissociation as a proactive, defensive response to the potential repetition of trauma (1998, p.273).”

At the same time that Bromberg challenges the clinical utility of Sullivan’s idea of a self-system developed to manage anxiety, Bromberg embraces Sullivan’s view of the empathy anxiety gradient as an apt way to understand what other theorists call the analytic holding environment. The interpersonal field between analyst and patient offers a pre-syntactic opportunity to access experiences that are beyond rational thought. Thus, Bromberg asserts:

it is not simply a matter of getting the patient to confront unconscious, repressed, dissociated or un-attended data. To do so may or may not create useful behavioral change, but it will not in itself lead to representational restructuralization. What keeps preconceptual . . . experience so rigidly unyielding is that the “me-you” representation is organized around

elements which are more powerful than the evidence of reason (1998, p.49).

He extends Sullivan's idea of the interpersonal field to include an analytic relationship that fosters access to pre-syntactic self-states that are beyond memory or reason. Another way to say this is that Bromberg is embracing the notion that the patient analyst relationship offers elements of a new more secure attachment that helps the patient affectively not just cognitively restructure self-experience. Yet this new attachment relationship must also make the patient uncomfortable enough, or generate enough anxiety that the patient's defenses can be experienced and articulated at the same time that the patient takes in the moment by moment soothing presence of the analyst. In so doing, the door is opened for the patient to experience self-states dissociated through trauma without becoming so threatening to the illusion of a unitary self that the patient is unable to tolerate the process.

The conception of psychoanalytic action in this passage resonates with Mitchell's idea of embeddedness and the ways that all facets of the relationship with the analyst become the basis for change. Trauma, in the sense that Bromberg uses it, is any subjective experience that threatens a unitary sense of self, which then activates defensive dissociative processes. This psychoanalytic theorization of trauma mirrors the DSM's definition of PTSD symptomology as one most often characterized by dissociation. Jon Allen writes that "clients with a diagnosis of PTSD have a high likelihood of being diagnosed with a dissociative disorder and vice versa" (2001, p.168).

In Judith Herman's seminal work on trauma, she writes that "The conflict between the will to deny psychological events and the will to proclaim them aloud is the central dialectic of psychological trauma. . . . The psychological distress of traumatized people simultaneously calls attention to the existence of an unspeakable secret and deflects attention from it" (1992, p. 1). Hermann further writes that these alterations in consciousness in traumatized people are what professionals call "dissociation." While Herman explores many different forms of trauma from sexual abuse to the atrocities of war, there exists in all of them the tension of the spoken and unspoken; put another way, what can be incorporated into the illusion of a unitary self, to borrow Bromberg's idea, whether that be individual or the collective memory of a an entire group, or whether that history must be kept silent, split off through defensive processes of individual and or group dissociation. Of course individual history cannot be separated from History in the broader sense, and often the trauma and dissociation in one mirrors the needs and imperatives of the other.

While trauma can be thought of as linked to an event or a series of events, trauma can also be understood as a subjective experience in which a similar event or series of events may affect different individuals in different ways. Thus, what may be experienced as a threat to a unitary self and dissociated or kept secret by one individual can be integrated by another. Here Winnicott's notion of a "fear of breakdown" (1963) is useful. Impingements in the caregiving environment or what he might call psychic deaths that already have occurred are dissociated and avoided for fear of breakdown. The subjective experience of anxiety can be so great that it leads to fragmentation, or in Bromberg's view, a unity of experience too traumatic to incorporate.

In an attachment framework, instinctual anxiety always predates trauma, but perhaps it is the quality of the attachment itself that makes individuals more or less susceptible to later trauma. Numerous recent studies have documented the connection between attachment style and susceptibility to symptoms of trauma such as anxiety and depression. Thus, in a contemporary trauma framework, anxiety is a common symptom of trauma. However, as Freud and Bowlby argue, anxiety also serves numerous adaptive functions. Trauma can derail these functions leaving the traumatized individual in state of anxiety with no termination point.

Psychoanalytic theorizations of anxiety and its functions from Freud to contemporary relational and trauma theory offer a multifaceted understanding of anxiety beyond the medical recognition of it as a symptom to be treated. Indeed anxiety within a psychoanalytic frame is not a disorder. It is indispensable to survival and an important component of treatment, without which growth and the restructuring of self-representation could not be possible. Psychodynamic psychotherapy offers a unique relational space in which the client can ultimately experience multiple self-states and yet over time retain their sense of unity. This is made possible by the safety of the attachment relationship between clinician and client, in which the termination of anxiety can only be found in seeking out and strengthening that connection.

CHAPTER V

Discussion

In the following composite case discussion, I hope to illustrate the ways that a relational approach can offer a comprehensive and effective way to conceptualize and to treat a patient experiencing anxiety. I also will use several classical object relations and interpersonal theories previously discussed in order to further illustrate them and to explicate this case. I purposely chose a case that is not emblematic of any one “anxiety disorder” in order to offer a counterpoint to the medical model. Like all patients, D’s case is unique. But it is also representative of a large proportion of students I saw throughout the year at the college counseling center where I did my field work, students who presented with general anxiety, social anxiety, and panic attacks, often co-existing. In this respect, D’s case captures the ubiquitous experience of anxiety, particularly within the 18-25 year old college population, the age group with the highest rate of onset of what are understood and treated within the medical model as isolated anxiety disorders. I also hope this case raises more questions about how anxiety manifests and functions intrapsychically and interpersonally within a systemic context and how anxiety can be an integral part of the treatment process when using a relational approach.

Introduction

D began individual therapy with me at the start of the academic year. From the outset, he had what I can only describe as an anxious presentation. He sat on the edge of his chair, and very rarely leaned back, his small athletic build taut with energy. While D was articulate, and I immediately liked him, he spoke rapidly, leaving few silences, as if words were a way of staying aloft, like a dragonfly who will crash if it stops flapping its wings. He spoke at length about what he did or thought, but very rarely about what he felt. D was born in the US to parents who emigrated from Morocco in order to attend college, and he spoke fluent Arabic. He had black hair, dark brown almond shaped eyes, and light tan skin. In the context in which we met, I would not have known his ethnicity by his appearance alone.

D's presenting concern was social anxiety that led to an experience of isolation at college. When he first came in for treatment, D was "hiding in his room" feeling as though he did not know what to say to other students, a seemingly paradoxical experience for someone who spoke so much in session. He also recently broke up with a girlfriend he met at college, which left him feeling further isolated and anxious. His girlfriend told him that interacting with him was like "talking with a stone" since he rarely expressed emotion. D also experienced anxiety around his schoolwork that led him to procrastinate and to underachieve in his own eyes. He had what he described as occasional anxiety attacks in class when his heart started racing and he sweat profusely.

D's family had moved a number of times during his childhood -- from the West Coast back to Morocco for two years when D was a toddler, and then returning to the US

where they moved several more times before finally settling in the Midwest. His family moved often enough that eventually he stopped trying to connect more intimately with peers. D described himself as “not letting himself get too attached” to any friends.

Throughout his childhood, D did well in school, and spent much of his time alone on the computer, either playing games or experimenting with web design and programming.

Though small in stature, D was good runner on his high school team.

During D’s junior year of high school, his parents separated, and his father returned to Morocco, where he remained. This separation was very upsetting for D, and he continued to struggle from the fallout when we met. D described his parents as having an unhappy marriage in which they were in constant disagreement over where the family should reside. D’s mother found work as a librarian in the US, but his father never found meaningful work. D characterized his father as an unhappy man who only took on intermittent, part time menial jobs. The family moved as his mother pursued better paying librarian jobs to support them, a situation that further undermined what D described as his father’s understanding of himself as “traditional Muslim man who is head of the family.” D’s father never settled into their life in the US and often spoke of his desire to return to Morocco to be with and care for his extended family in the town where he grew up. D’s mother, on the other hand, had no interest in returning and wanted to remain in the US so that her children could take advantage of the educational opportunities here. With this fundamental conflict structuring the marriage, D grew up feeling as though he did not want to “add any more worries” to an already stressful situation. He “kept his head down” and did his schoolwork. Further into our therapy, he spoke of the way that the stress and unhappiness between his parents, and the lack of

communication and emotional connection in the family, became so “familiar to him” that he is not sure what he felt as he was growing up. Indeed this was a common theme that surfaced throughout our work together: often D did not know what he felt outside of an experience of anxiety, and if he had some awareness of his affects, it was difficult for him to communicate them.

A consideration of intra-psycho and interpersonal theories within a relational treatment

While I agree with Mitchell’s assertion that the monadic and intra-psycho emphasis of Freudian theory makes it difficult if not impossible to integrate it with the dyadic focus of relational theory, aspects of Freud’s conception of anxiety as a signal offer a useful entry point for this case. Through a Freudian lens, D’s anxiety can be understood as a signal for repression as a primary defense. However, D did not repress his drives or his id impulses. Rather repression acted as a defense against the experience and expression of affect within his formative relationships and within a broader social context.

As our work together proceeded, D became increasingly able to articulate how difficult it was for him as a child growing up around the uncertainty and tension within his parent’s marriage. After a time, D admitted that he resented his father for his “unwillingness” to adapt to life in the US, and he felt sorry for his mother who was left largely responsible for the family’s emotional and financial well being. Furthermore, D described his father’s unhappiness and diminished self-esteem within their home as part of a broader discomfort within the cultural and social practices here in the US, many of which conflicted with what D described as his father’s “religious upbringing.” Already a

quiet man by temperament, his father became increasingly marginal over the years. It might be said that his father's experience in his family became a parallel process for his experience of displacement and marginalization on multiple levels within the US. His experience can also be understood as racial melancholia, a kind of extended mourning for all that was lost in the process of immigrating to a predominantly white western culture (Eng and Han, 2000). D said that this situation made his father very short tempered with D and his brother, two years his junior. D's brother also struggled academically. This generated more pressure on D to reduce the level of stress in the family. On the rare occasion when D expressed any unhappiness to or with his parents, it only increased his father's anger and the conflict between his parents. As he got older, communication with his mother often led to judgments and coercion by her if D held different points of view or expressed emotions that did not make sense to her. Understood within this very basic outline of D's relational, cultural, and socio-economic matrix, the experience and expression of affect became unsafe, a source of anxiety, that further threatened the somewhat tenuous stability of his family's life in the US. Thus, it can be argued that repression served an adaptive function in relationships, and D's anxiety, from a Freudian perspective, constantly signaled the ego's activation of this defense.

While Sullivan (1953) eschewed Freud's structural model of the mind, Freud's (1926) later notion of the way anxiety functions resonates in many ways with Sullivan's interpersonal perspective. Within an interpersonal framework, D's self-security system developed in order to reduce his experience of anxiety in relationships. For D, "good me" might be the son who did his schoolwork and contained his emotions in order to embody his parent's needs and expectations of him. While "bad me" might be the son who

complained or got angry or sad, the son who felt responsible for his parents' conflicts as a couple and in some ways for their individual unhappiness. The daily anxiety that D experienced at college might then be understood as his self-security system whereby limiting his social interactions and an anxious focus on schoolwork repeated the same security operations for managing anxiety that he used while at home. These attempts to reduce anxiety functioned largely outside conscious awareness, leading him to feel isolated and anxious without any apparent explanation in the present. Indeed upon entering therapy, D stated that there was no good reason for him to feel so anxious in the present at college, and in this respect, his "security operations" created mild dissociative states, or what might also be called temporal dislocations within his self-experience. This apparent disjuncture is part of what led D to seek out therapy even as he avoided or "repressed" affective expression in his daily life.

A Kleinian object relations frame regarding affective development raises the important question of what happens when powerful affects such as love and hate are not more fully experienced and expressed. D's internalization of his own parents as both caring, "good objects" and as vulnerable or punishing people --"bad objects"-- who could not tolerate affect left him in a position of trying to adapt himself to repair them, or at the very least, trying to avoid pushing them further apart. For Klein (1952), love and hate are derivative of the libidinal and aggressive drives, and are therefore universal. However, while affects and certain relational processes of rupture and repair may appear "universal," the meaning of love and hate and how they structure relationships is not. Like all affective phenomenon, the meaning and experience of love and hate is subjective, and how they are understood and expressed in relationships is culturally and

socioeconomically contingent. In this regard, D's father's return to Morocco to be with his extended family was, according to D, an expression of love and belonging within his father's belief system, even as he left the nuclear family that Americans tend to prioritize. Yet D was also profoundly hurt and angered by his father's unwillingness to adapt to American life for the sake of his nuclear family, a choice that D said he did not want to reproduce in his own life. It was not until the final weeks of our work together that D expressed a greater range of affect about his family and his father in particular.

Within a Kleinian formulation, it can be argued that D engaged in forms of splitting characteristic of the paranoid schizoid phase in which powerful affects cannot be integrated or experienced in relationship to the same objects. While I am not suggesting that D's has a 'schizoid' personality or emotional make-up primarily rooted in early traumas in the caretaking environment, Klein's theorizations (1952) also argue that splitting and other schizoid defenses are an integral part of both 'pathogenic' and 'normative' development, and these defenses continue to function in all people, to a greater or lesser extent over the life course. Viewed through this lens, D's inability to express hate (or perhaps more accurately, anger) toward his father and in relation to his own experience of abandonment, can be viewed as a kind of splitting wherein his father, the loved object is protected from D's anger and or "hate." These split and disavowed affects are then projected onto his father and the rest of the world and then, according to Klein's circular processes, introjected, thereby heightening D's annihilation and persecution anxiety in relationships; a formulation that helps explain the degree of D's social anxiety, and his recurring fear that other's were angry with him or did not like him that arose throughout our work together.

Just as D split or disavowed hateful affects, he also disavowed powerful feelings of love and desire. While he experienced himself as having these feelings (for example in relation to his ex-girlfriend), others, including myself, often experienced him as flat or inexpressive. Rather than integrating and expressing these affects, D projected and introjected them creating the relational dynamics in which D tried to meet the needs and desires of others, whether that be his parents, his girlfriend or me, but did not fully experience and express his own desires and or loving feelings. Whenever D's defensive processes for managing and splitting "loving" as well as "hateful" affects was threatened, the possibility of further integration itself became a source of anxiety. Thus, D "kept his head down," and did not clearly express his needs or desires at home, just as later in therapy -- as the next section will clarify -- he was unable to fully express his needs and desires with me.

On a number of occasions, D also worried that he would become like his father -- disconnected from others, angry and alone -- and in this regard splitting and projection also protected D's ego in the inevitable process of identification that takes place between parents and children, and fathers and sons in particular; by protecting (his father) from his anger and or hate as well as love, D also split these affects from himself, protecting himself as a he grew into a man, from the "hated" father who is also part of him. The cyclical patterns of projection and introjection that structure relational patterns from the outset are part of the processes of identification, which continue to occur throughout all development. However, as with the use of Freud's theorization of anxiety in a relational context, D's affects are not derivative of libidinal or aggressive drives, but are only experienced within a relational matrix that is contextually shaped and bound. D tried to

understand the cultural and familial expectations that helped shape his father's idea of relationships and the affects that structured them, but D grew up within a different cultural context than his father, one that realigned his emotional and relational priorities in a way that complicated his identifications with his father. In this regard, the concepts of splitting and projection can only be understood as part of the complex ways that D straddled two worlds, growing up in a very different context from either his mother or father.

While Klein and Sullivan offer useful lenses for understanding anxiety in this case, both theories clearly have their limitations. To speak of D as having a good or bad self or to speak of D's intra-psychic experience in object relational terms, as being composed of good and bad objects is unnecessarily reductive. After all, what is a "good" or "bad" self or object, and what do these words even mean to the person in treatment. While Sullivan embraced the decentered idea that a unitary self was a necessary illusion, the very idea that this illusion can be broken down into categories of good and bad is also an illusion. From a relational perspective, a closer approximation of the "truth" is to say that D learned and internalized a set of patterns within the particular relational matrix of his family and these in turn exist in a dialectic with his own intra-psychic processes.

Mitchell writes that he uses the term:

'relational matrix' in an effort to transcend the unfortunate tendency to dichotomize concepts like interpersonal relations and 'object' relations, or the interpersonal and intrapsychic, as if a focus on either side necessarily implies a denial or deemphasis of the other . . . *The most useful way to*

view psychological reality is as operating within a relational matrix which encompasses both intrapsychic and interpersonal realms (1988, p.9).

However, a focus on interpersonal relationships and intra-psychic processes that does not understand them within a broader socio-economic and cultural context is also limited and distorting. D's family, like every family, was decidedly shaped by their social status within a given context. Their particular experiences of immigration and the economic, social, and cultural forces with which they contended as they sought to build their life in the US and how these forces interacted with the relational patterns and social contexts that predated their immigration – all of these forces create the decentered “truths” that various theories attempt to organize. While this last point may seem self-evident, a relational focus as articulated by Mitchell can obscure that family only exists within an infinitely complex dialectic with other systems. In this regard, the various manifestations of D's anxiety are inextricably interwoven with the larger socioeconomic and cultural systems of which he and his family are a part. While the idea of a nuclear family suggests a core around which everything else orbits, the relational matrix in the most complex sense is more like a set of crosshatched lines and shapes moving in all directions, both familiar and perplexing, a Jackson Pollack painting in which the analyst and analysand work together to discern patterns and meanings.

These overarching theoretical considerations point to the question Bromberg (1998) raises in his critique of Sullivan's personifications. No matter how we frame or populate a patient's intra-psychic landscape through classical and object relations theory, and no matter the degree to which we try to maintain some objectivity as participant observers within an interpersonal approach, this central question remains: How does the

self or for the purposes of this discussion, D's self-experience, particularly with anxiety, undergo representational change within treatment, and what creates the therapeutic action? The section that follows explores the ways that D and I grew together as our relationship itself increasingly became the vehicle for change.

Like the discussion of every individual with whom we work, the frameworks I use so far in this discussion generate a particular set of meanings that inevitably prioritize and/or exclude other information and meanings. Likewise, the focus on anxiety as a phenomenon as well as the use of theories that are not fundamentally dyadic generate their own tone and emotional tenor in the writing itself. While I tried throughout the previous section of this discussion to retain the integrity of D's presentation as understood through my own limited subjectivity, the largely monadic theoretical focus of the previous discussion creates a tone that is more "analytic" and removed than collaborative. Rather than edit this to produce writing that might be more reflective of my own relational and inter-subjective experience of treatment, I think it is equally important and instructive to try to capture the ways that different theoretical orientations not only shape the therapeutic relationship, but the writing about that relationship as well. A monadic approach and even Sullivan's less removed but professionalized and "empirical" participant observer create what can only be called expert distance since the analyst must remain outside of their client's experience to some degree in order to treat them. It is also possible that D's lack of affective expression at various points in our work together, finds a parallel representational process in this writing.

The embedded analyst and attachment

D and I met weekly throughout the fall semester. We often spoke of his relationship with his ex-girlfriend who also lived on campus. They had been a couple throughout freshman and sophomore years. This relationship was the most intimate connection D ever made. Yet in the final months of the relationship, they often fought about D's lack of emotional expression. She began to feel that he did not really love her, even though from his perspective, he felt as though he gave her a lot. D bought a car with money he made over the summer, and he drove his girlfriend everywhere. They ate all of their meals together, and if she needed any help when she was overwhelmed with schoolwork, D was always ready to lend a hand doing whatever was needed whether it was laundry or shopping. She accepted this help and care, and yet she said she did not feel loved. D began to resent her for all that he gave her and her lack of appreciation, while she felt increasingly disconnected from him.

As we explored what happened in this relationship, D and I discovered that there were many things he felt in relation to his girlfriend, but he was so anxious about expressing himself that he either lost track of his emotions in her presence or became paralyzed, unable to express them. Despite his trouble communicating, he did not understand how the things he did for her did not adequately express his commitment and love. As we continued to meet over the fall semester, D began to regret that he did not express himself more fully with her. He still ran into her on campus and they spoke, but he remained too anxious to disclose more to her. In the context of this relationship, we began to talk about the ways that love in his family was expressed through sacrifice and fulfilling obligations, as his mother had sacrificed for him and his brother, and his father

sacrificed for his extended family. In his effort to avoid becoming like his father and mother, D assiduously attended to his girlfriends needs to demonstrate his commitment to “making things work.” Often as D spoke of his girlfriend and the ways his relationship reminded him of patterns in his own family, his voice would occasionally quiver, or his eyes would grow moist. When I pointed these things out to him, D initially became self-conscious since he was unaware of them. Usually he would cough or run his hands over his face as if to wipe away whatever was there, and would shift the tack of our conversation to another subject. However, as D and I got to know each other better and established increasing trust, I began to ask him what it was like for him in the moment to share his emotions with me. While this question initially appeared to make D anxious, over the course of the semester he began to feel that this was a new and valuable experience for him.

This process can be understood as an embodiment of what Sullivan called the empathy anxiety gradient between patient and therapist (1953). Expressing and experiencing affective states that D usually avoided increased his anxiety, but not to the degree that that therapy itself became unsafe for D, threatening what Winnicott (1963) called the therapeutic holding environment.

Paul Wachtel (2011) theorizes this process in therapy as a form of exposure. He writes:

In the process of promoting insight, or interpreting (and hence interrupting) defenses that keep the patient out of touch with his experience, a successful psychodynamic therapy brings the patient *into closer contact with* the experiences that have been warded off. The patient

thinks the thoughts and feels the feelings that he previously avoided – or put differently he is *exposed* to them. . . . Interpretation and self-knowledge do contribute to the process, but something else that is very important is also involved. The process of change proceeds to a significant degree through direct experience. . . . What we know about exposure as a general process suggests that usually it is necessary for the patient to experience repeated exposure for the anxiety to begin to significantly diminish (Wachtel, 2011, p.11).

Early in his career, Wachtel worked closely with cognitive behavioral therapists, and he views exposure as a methodology common to both psychodynamic therapy and CBT, suggesting that the theoretical boundaries dividing different practices are not as rigid as they appear. While I consciously used elements of CBT with a couple of other patients experiencing anxiety, I did not do so with D. However, Wachtel's description of the process of exposure and therapeutic change aptly describes some of the key elements that occurred with D. As we continued our work together and D was repeatedly exposed to affects that he previously avoided, these parts of himself became more integrated into his self-experience, reducing his anxiety around their expression. It is useful to point out here that the splitting of powerful affects that define Klein's schizoid phase are further integrated by the ego through an empathy anxiety gradient around affective expression that also occurs over time in the therapeutic process. (Again, the organizing frame of intrapsychic processes can usefully be understood within a relational matrix and not as drive derivatives.)

At the outset of Wachtel's article, he explicitly writes about the difference between writing about therapy as if looking down on a landscape from "30,000 feet" where the "contours" of the relationship are "easy to grasp" in contrast to the actual experience of doing therapy -- the view from "ground level" in which the experience is far more complicated, "unpredictable" and "confusing" (2011, p.3). If this is not occurring, than something important is in fact missing from therapy. The process of writing about D or any individual in treatment inherently imposes a retroactive order and meaning that is not wholly consistent with the embedded and often confusing nature of the therapeutic process itself. Wachtel provides transcriptions of his sessions so that the reader can see the therapy from ground level "warts and all" (2011, p.3). There is not the room here to do this, nor does a composite case study make this possible. More importantly, transcriptions and language alone cannot capture the experiential nature of therapy. Along with language, therapy is transacted through the body, through pre-syntactic non-verbal communication, and an experience of empathic connection that language can only grasp at. Thus, no representation can ever really be at ground level, and though I strive in this section to capture the collaborative quality and texture of the relational matrix in therapy, this discussion is at best an approximation of experience.

As I sat in session with D, at times I found myself feeling uncharacteristically tired and a little removed. D's rapid, concrete, and anxious style of communicating carried me along on what I came to think of as a kind of ride on a raft above constantly moving waters in which we avoided or had limited access to his emotions. As he sat on the edge of his seat, filling the silence, there were moments when I experienced what I can only describe as mild dissociation in which I could not anchor our shared experience

in any affect other than an experience of anxious avoidance. Yet there were always moments in each session, which increased in frequency and duration as we worked together, when D slowed down, when he stopped and tried to clearly articulate and experience what he was feeling. His reaction of coughing and wiping his face when his eyes softened and he appeared to be feeling various affects became a signal for us to slow down. I made this transparent in our process together, asking D directly if it would be useful for him if I pointed out these moments so that we could slow down and explore what he was experiencing. D agreed that this would be helpful, and in this way we devised one entry point by which to explore D's affects.

Just as I experienced in my body the kind of dissociative states that D brought into the room, I also experienced moments of deep empathic connection to him in which my own eyes softened and become tearful, or where I would laugh or smile along with him. Sometimes I felt sadness and compassion or anger as we sat together, even when D did not appear to be accessing these affective states himself. This suggests projective identification, but rather than viewing this as a defense, projective identification may also serve the adaptive function in therapy of allowing the therapist to inhabit affective experience that cannot in the moment be accessed through language by the patient, so that he or she is no longer alone. No doubt my affective responses were translated through my own non-verbal communications either in tone of voice, body language, posture, and facial expressions that were a genuine reaction to what I felt in the moment. This further mirrored and exposed D's affective experience.

Although Sullivan used the idea of empathic linkage to describe the ways that mothers deposit anxiety into their children, this concept might also be applied to the

multitude of affective states that are constantly passed back and forth between therapist and patient through empathic attunement and the avenues by which this is expressed. As Beebe points out in her work with adults, which draws on her experiences with infants, non-verbal forms of communication tap into pre syntactic brain functions that help the patient integrate and regulate their own affective experiences (Beebe et al, 2005).

Over time I came to think of D's rapid, often affectless speech as a socially acceptable replacement for strong affects, and as a means of integrating himself into America in a way that his father did not. Several times in our therapy, D wondered aloud if he would become like his father in the ways his father was silent and struggled to connect with others. In this respect, I understood D's rapid, anxious speech as an attempt to connect, to fill in the silence, and to create a different identity than his father, particularly when he could not express emotion more directly. Paradoxically, the desire to connect and to differentiate himself from his father at the developmental crossroads of early adulthood, also recreated a different form of disconnection from others.

My bodily experience of tiredness and being at an emotional remove that sometimes occurred in our sessions can be understood within Bromberg's formulation as shared disassociated self states. Bromberg (1998) specifically speaks of self-states disassociated through trauma, so that adaptive disassociation becomes a defense that protects self-representation from affects too threatening to integrate into the illusion of a unitary self. The emotions or self-states that D split or experienced as too threatening within his relational matrix were thus surrounded by inexplicable anxiety in the present which did not appear to be attached to any overt cause. This led to the self-understanding that I saw in many patients including D -- namely that like D they were, by nature, very

anxious people since there often was no apparent causal explanation for the degree of their anxiety.

Enactment

As we met over the course of that first semester, D reported that he was feeling less anxious in his classes. Likewise he made several friends in his residence with whom he now regularly ate meals. As he grew up, D's family moved to several different towns where they were the only Moroccans. The time D spent alone in his room on his computer mirrored the kind of cultural isolation his family experienced in these towns. D's two new friends in his residence were first generation Korean-Americans, and though D did not say so directly, I assumed that this was part of their connection at a predominantly white college. Upon his return from the winter break, D seemed excited for the new semester, and had seemingly cracked some of his social anxiety and isolation through contact with his new friends.

At this time, my own caseload increased significantly as more and more students sought counseling. In its mission statement, the counseling center states that they are a brief treatment clinic. Although many clinicians in the system see patients longer term, some of the staff only work within a brief treatment model. Likewise many therapists there see patients every other week in order to fit everyone into their packed schedule. As my own caseload mounted and I felt some anxiety as an intern about how I would manage, I reevaluated whether weekly therapy was possible with some patients who were not suicidal or in some other more imminent crisis. Since D seemed to be less isolated and anxious than when he entered therapy, I decided to ask him if he would be willing to meet every other week due to mounting demands within the system. D said that he

understood my position and agreed without hesitation to switch over to bi-weekly meetings.

In our first biweekly session, I did not notice any particular difference in D's presentation or the way he related to me. However, over the next two sessions, D reported that he was once again experiencing panic attacks in class. His heart raced, and he sweated profusely. This had happened to him in the past, but not in recent months. In our third biweekly session, I asked D what he was experiencing in these moments, and he said that he felt totally alone while surrounded by the people in his class. As we spoke of this experience and how to address it, I felt somewhat powerless, perhaps an expression of the way D himself felt when experiencing these panic attacks. I also felt increasingly disconnected from D. Coupled with a sense of powerlessness in the face of his panic attacks, I offered D some concrete ways by which he could try to soothe himself and to reduce his panic. Together, in the office, we practiced diaphragmatic breathing, something I did when I was on call and spoke on the phone or met with students who were experiencing intense anxiety and panic. Likewise borrowing from some of the CBT I had done with a couple of other patients, we explored D's thoughts leading up to and during his panic attacks. Then we explored alternative thoughts that might soothe him. While D gamely joined me in these exercises, I could not help feeling like they missed the point. Looking back, I can see that I felt guilty for reducing our contact, and it made me feel better to offer him a concrete solution even if it was not helpful to him. At the end of the session, as I pulled out my appointment book, I asked D whether it might be helpful to meet in a week, and he said that he thought it would. As he stood up to leave, I asked him whether it was hard for him to meet less frequently, and he immediately told

me that it was harder to maintain a sense of connection. A look flashed across his face that I had not seen before, but that I understood as barely concealed anger.

In our next session, I asked D more about how he felt about meeting bi-weekly. He reiterated that it was hard to stay connected with me, and I asked him why he did not say something about this sooner. He said that there was no reason for him to feel this way since it was not my fault but the demands of my schedule at the counseling center. It became clear that D felt he had no right to feel angry or hurt by my decision since it was out of his and my control. In this moment, it also became clear to me that together we enacted something very powerful for D. Throughout his childhood as D's family moved from place to place and when his father ultimately left, D had no agency. Whatever D felt made no difference, since it did not change the outcome. I asked D if he ever would have told me how he felt about meeting bi weekly if I had not brought it up. He said that he probably would not since it was out of his control, and therefore his feelings about it did not matter. I apologized to D for not thinking through what this change might mean for him. I apologized for hurting him, and as we sat in this session, D seemed more present than he had in weeks.

Over the course of the following week, I talked in supervision about what led me to reduce our contact, and realized that it was not only the demands of the system and my anxiety about managing it. I realized that D's limited affective expression in our sessions left me feeling uncertain about the importance of our work together and how he felt about it. In a sense, like his girlfriend, I did not know what D really felt, and this created a lack of connection and understanding in me. In our next session, I was transparent about all of this. As the words left my lips, I realized that when I detected a slight quiver in D's voice

or his eyes appeared to soften this was the most that he could express. While I could argue that my decision to decrease our time was simply my inexperience as a therapist, this is at best a partial truth. Within his raft ride style of communicating, moments of emotion, no matter how brief, lost some of their meaning and impact on me. Just as D did not let himself get too attached to his friends as he grew up, I did not let myself fully experience the attachment between us that had grown over the months. D acknowledged that he did not express to people what they meant to him, and he realized that he had done the same in our therapy.

It is important to observe here that D's "anxiety symptoms" escalated after the reduced contact following our switch to a biweekly schedule. It is also useful to understand what occurred in our therapy and in this particular enactment within an attachment framework. Bowlby understood separation anxiety as the corollary to attachment. Indeed our increased separation heightened D's anxiety, and it could be argued that this experience activated the "primary anxiety", that within Bowlby's attachment framework, is an evolutionarily adaptive part of every infant's development. While I do not know specifically if D suffered any particular attachment "trauma" with his mother as an infant, this is not the important issue. Rather, D's case powerfully illustrates the highly adaptive function of attachment, and that if attachment behavior is interrupted or compromised in any way, the kind of primary anxiety that Bowlby describes, cannot be successfully comforted. While I am not arguing that adult and infant attachment fulfill the exact same needs, they operate along similar adaptive patterns; attachment behaviors that structure caregivers and children remain the foundation for human development and connection, and this is no less true in therapy than in any other

relationship. Paradoxically the forced separation and anxiety that followed the shift to biweekly sessions with D, generated the adaptive anxiety that signaled the need to connect, to reaffirm our attachment and all the comfort, safety and validation that comes along with this very human process and need. Paradoxically the rupture that occurred within our attachment provided the opportunity for repair. This allowed D to experience a traumatic childhood relational pattern in a connected and less anxiety-producing manner.

In this same session, I raised the issue of our impending termination since there was only three weeks left of the semester. D expressed sadness and anxiety about terminating, stating that he was anxious about feeling “all alone again.” I told D how much I would miss him, and that if we worked under different circumstances within a different system, I would love to continue working with him. As we spoke about termination, D’s eyes began to well up, and for the first time all year he began to cry. For a time, he could not stop. He said that the only other time he cried like this was while he read a book in which the main character’s father leaves. He also stated that he was afraid of crying like this because he could not stop or control it.

Here Winnicott’s notion of fear of breakdown offers another useful lens through which to understand this moment. D’s experience of these powerful affects was not necessarily frightening or overwhelming because they were new; rather D’s fear of a loss of control is also a re-experiencing of psychic deaths that already occurred. While Winnicott specifically theorizes “fear of breakdown” in relation to psychotic patients, Winnicott’s formulation also suggests the broader fear of a fragmentation of self-experience and fear of isolation that reenacts traumatic ruptures in past relationships.

Here, the fear of breakdown could perhaps more usefully be framed as a fear of being alone, a loss of connection to caregivers, or put more succinctly, the fear of traumatic disruptions to attachment that recapitulate previous traumas.

At our next session, as we continued to process our impending termination, D cried again in the same manner, and it was as if all the sadness, loss around disrupted attachments, and missed connections that he had experienced for years was with us in the room. For what was perhaps the first time all year, D leaned back in his chair and remained silent for some time as the tears came down his cheeks. D then expressed some confusion, fear, and embarrassment about his display of emotion. I told him that the effect of his disclosure and emotional honesty is that it drew me closer to him, and that I felt even more deeply connected to him as a person. There is no theory or transcription that can capture what this session was like. I can't help but wonder if one of the only termination points for anxiety is through a strong loving connection to another person.

In the two weeks between these sessions, D began to express more emotion with his two new friends and stopped worrying so much about how they would respond or whether they really wanted to be friends with him. He felt the onset of a panic attack in one of his classes, but he said that he felt less alone and was able to calm himself to some extent. While I do not think D was "cured of anxiety" as a symptom, I do believe that through our relational matrix, D was able to alter his self experience in relationships, which reduced his anxiety. Likewise, without anxiety as a dynamic force in the process of affective exposure and change, treatment would at best remain a conversation like many others, stripped of an important element in the process of change.

It is very possible that focused CBT may have reduced D's level of anxiety just as much, if not more so than a relational approach. But the value of anxiety reduction as a goal of treatment is not really a worthwhile abstract discussion, since as this case illustrates, anxiety does not exist as a separate entity apart from other relational experiences and systems. While there is no way to manualize a relational approach or to say that a diminishment of symptoms will occur in some set time frame in order to appease an insurance company or the systemic demands of a given clinical setting, there is little question to my mind that unless a patient has a distinct biological/genetic predisposition for anxiety, anxiety symptoms, at least as they appeared in the vast majority of college students that I saw over the course of the academic year, always exist within a relational context. Medicating these symptoms or providing time limited more prescriptive therapies such as CBT helps some patients, as it did several of my own. But to medicalize anxiety as a disorder and to primarily treat it as an isolated symptom to be eradicated, is a willful distortion of experience that eliminates treatment options that clearly offer long lasting, satisfying and comprehensive outcomes even if they do not work within the systemic and "empirical" prescriptions of a medical model.

As my work with D also illustrates, systems and the ways that individuals are inextricably interwoven with them, shape the relational matrix that structures every treatment, no matter the context. However, when systemic and socio-economic demands determine treatment without recourse to an open, collaborative and comprehensive assessment of an individual's needs, a great deal is lost. I am happy that D and I were able to repair a rupture that was in part generated by systemic demands. For many people, especially those without certain kinds of social status and privilege, systems often

become even more rigid and hierarchical reflecting imperatives that have little to do with individual need or the needs of an entire community as is often the case. I hope that my work with D helps stress the need for assessment, collaboration and treatment that is not rigid, prescriptive or bound by allegiance to any one theory, but is responsive to the full complexity of each person's experience.

Conclusion

This study has traced some of the main psychoanalytic theories of anxiety and the ways that anxiety has been conceptualized within treatment, yet no one theory adequately defines what anxiety is, what are its functions, and explains whether it can be defined when understood in terms of discrete disorders. However, rather than offering a more “definitive” theorization of anxiety and its treatment, it might be more useful to talk about my experience reading all of the different theories that informed this work. There is not a single theory included in this study, which did not offer insight into anxiety and the conjoined intrapsychic and interpersonal functioning of the mind. As I immersed myself in each theory, I often felt that the writer was capturing something essential about anxiety and lived experience. For better or worse, since its inception psychoanalysis has offered totalizing theories and also sought to explain anxiety in a similar way, attempting to capture what is beyond explanation. Immersed in the depth of each theorization, I often found myself feeling as though it achieved its goal, and the working of anxiety in the mind and body was now manifest. But this always turned out to be an illusion endemic to powerfully articulated systems of thought. For as soon as I read a new theory, I often felt equally immersed and convinced.

As I hope my discussion illustrates, the explanatory power of different theoretical frames can always unlock new understandings, but no one theory can embody the “truth.” The premise of relational theory is that there are multiple, often competing truths. Meanings, ideas and experiences extrapolated through different theories can exist alongside each other without forcing an individual to conform to a certain theory or approach which rests on a truth claim about a phenomenon like anxiety, its functions and treatment. However, the fundamental premise of this study, that anxiety can best be understood and treated within the particularities of a relational matrix that is unique in some sense for each person, is itself a centering truth, but one that currently seems to offer the farthest and broadest view into the distance with the fewest obstructions.

CBT and medication are also part of this relational landscape and are not antithetical to psychodynamic treatment. As Paul Wachtel argues, there is a great deal of overlap in some ideas, since at their core, every mental health treatment is in some sense relational. However, treatments that focus on eradicating or reducing a specific symptom like anxiety exist in an easy dialectic with the current medical model, and the very symmetry of this union can obscure all that it leaves out. This symbiosis also presents a particularly difficult challenge for substantiating the validity of psychodynamic treatment. Indeed the very structure of this thesis and the phenomenon chapter that begins it belies an inherent tension between psychoanalysis and the evidence based medical model. Within this dominant system, psychoanalysis must try to become systematized and prescriptive in order to render itself quantifiable and therefore viable. Yet the very nature of psychodynamic theory and relational treatment presumes that a phenomenon like anxiety is not necessarily a disorder, and can also only exist within the idiosyncratic

relational matrix of each individual. This makes a prescribed treatment difficult if not impossible to delineate. In this regard psychoanalysis is left trying to produce evidence within an empirical classification system that runs counter to its very logic, a system that often ignores the contextual and personal nature of self-experience.

There is little doubt that D experienced a great deal of intra psychic and interpersonal anxiety, but this took shape over the course of a life that was defined by relational experiences within various systems including his family and more broadly by his family's particular experience of immigration to the United States, and the socio-economic, cultural, and emotional impact that this adjustment had on them. Likewise in treatment with me, D's anxiety did not exist as an isolated symptom but waxed and waned, and over time appeared to dissipate as our relational matrix unfolded, and our connection and attachment offered the space for new self-representation and experiences. No case study, series of case studies, or empirical study can make the validity of a given treatment approach generalizable for all people. However, the bias of this study is that every person's experience is richly contextual and relational. Any treatment that willfully ignores this on the basis of "evidence" supported by a dominant paradigm, runs the risk of prioritizing systemic imperatives driven by socio-economic forces and ideology, over the needs of the individual and the communities of which they are a part.

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