Anxiety is a universal emotional experience precipitated by ordinary concerns and worries. Pathological anxiety is the most common clinical presentation in psychiatry either as the primary symptom or as a major accompaniment of many psychological disorders ranging from the neurotic to the psychotic. Anxiety disorders, phenomenologically united by the subjective experience of overwhelming and disabling anxiety that appears to have little basis in reality, have been classified into various discrete entities in DSM-IV-TR. However, with the exception of obsessive-compulsive disorder, this taxonomy may be more illusory than real because “pure” forms of these disorders are not common, and comorbidity studies have shown that one type frequently overlaps with another. Unlike illnesses in which depressive affect is dominant, the classification of the anxiety disorders seems more like the charting of unstable and shifting islands in a sea of anxiety.

Some differentiate fear as an evolutionary adaptive response to conscious real dangers (the phylogenetically determined fear-flight response) from neurotic anxiety, which is seen as a reaction to unconscious dangers. Freud addressed the latter and used the term anxiety neurosis to encompass acute anxiety attacks (modern panic disorder), chronic anticipatory anxiety, and phobia. He observed that all three could lead

1Although now classified with the anxiety disorders, obsessive-compulsive disorder is addressed in Chapter 3, “The Obsessive-Compulsive Patient.” It is clinically distinct and may be unrelated etiologically to obsessive-compulsive personality disorder, but the psychodynamics of both have much in common.
to agoraphobia, a constriction of everyday life designed to prevent exposure to situations that would lead to crippling anxiety. His century-old classification anticipated aspects of the modern taxonomy of the anxiety disorders. Freud’s early theory of the cause of neurotic anxiety was essentially a physiological model in which he postulated that anxiety resulted from a damming-up of undischarged libido (his actual neurosis, so-called because he thought it was based on a somatic process). Later he developed a psychological theory of anxiety as a signal of unconscious conflict heralding the dangers of a forbidden instinctual wish being expressed and acted on. In this construction, signal anxiety represents unconscious conflict between sexual or aggressive wishes and the countervailing forces of the ego and superego. The ego mediates the limitations of external reality while the superego arouses fears of retaliation and punishment if forbidden impulses are acted upon. The patient with neurotic anxiety often has no conscious awareness of this psychodynamic mechanism.

Freud’s model of the origins of anxiety is an ego-psychological one. Modern thinking also encompasses constitutional factors and the object relations of childhood development. The innate capacity to manage everyday anxiety is thought to be highly dependent on the biologically based temperamental disposition of the infant. Some newborns are more reactive and agitated by both external and internal stimuli than others. Those who are high-reactive may go on to show greater stranger anxiety and more persistent separation anxiety. Separation anxiety—the fear of the loss of the caretaker on whom the child is dependent—is a universal aspect of development and in the temperamentally vulnerable person can persist beyond childhood. Neuropsychological irritability combined with separation anxiety continuing into adulthood is posited by some to be at the core of panic disorder.

Generalized anxiety disorder, panic disorder, and phobia all possess a common theme, namely a low, probably biologically based, threshold for the toleration of anxiety. Hence, they are clinically interrelated and may overlap. Phobia and panic disorder are especially intimately connected and are often aspects of the same clinical syndrome. The experience of frightening panic attacks leads to a constriction of life, an avoidance of specific situations—agoraphobia—that might potentially lead to the precipitation of such attacks. Agoraphobia and specific phobia can be viewed as, in part, a defensive reaction on the part of the patient. The choice of phobia and its symbolic meaning have important psychodynamic elements.
PSYCHOPATHOLOGY AND PSYCHODYNAMICS

The Phobic Patient

Phobic behavior is found in a wide variety of neurotic, characterological, and psychotic syndromes (Table 8–1). Phobias and panic attacks can be differentiated from generalized anxiety disorder and posttraumatic stress disorder, although they have many features in common. The distinctions are considered in the section on “Differential Diagnosis.” The phobic person copes with his inner emotional conflicts and anxiety by attempting to repress his disturbing thoughts and impulses. When this repression fails, he displaces his conflict to a place or situation in the outside world and tries to confine his anxiety to that situation. The external situation now symbolically represents his inner psychological conflicts; if he can avoid this situation, he can decrease his anxiety and obviate the possibility of a panic attack. It is this avoidance that is the essence of the phobia. The specific symptom may be a symbolic condensation that includes aspects both of a forbidden wish or impulse and of the unconscious fear that prevents its direct gratification. Other unconscious determinants may include threats to attachment and a chronically impaired sense of safety. Phobic defenses lead to a general constriction of personality as the patient relinquishes freedom and pleasurable activity in order to avoid conflict and anxiety.

The term phobia is sometimes misused. The “cancer phobic,” for instance, has an obsessive fear, or perhaps a hypochondriacal idea, but not a true avoidance. Another misuse is illustrated by the phrase “success phobia,” which refers to a psychodynamic formulation explaining an unconscious fear of success. The patient with “cancer phobia” may avoid going to hospitals, and patients with “success phobia” may avoid vocational advancement because of unconscious fears, but these are not true phobias in the traditional sense.

DSM-IV-TR attempts to differentiate specific phobia from panic disorder with agoraphobia but acknowledges that this may be difficult, because both disorders may include panic attacks. Again, this speaks to the overlapping nature of the anxiety disorders and their common origins, namely, a constitutionally based low capacity for tolerating anxiety.

Phobic Symptoms

The phobic individual is characterized by his use of avoidance as a primary means of resolving problems. In the classic phobic reaction, neurotic symptoms dominate the patient’s existence. His mental life centers on unrealistic and distressing fears (open spaces, heights, subways, etc.).
### TABLE 8-1. DSM-IV-TR diagnostic criteria for specific phobia

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder (e.g., fear of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), separation anxiety disorder (e.g., avoidance of school), social phobia (e.g., avoidance of social situations because of fear of embarrassment), panic disorder with agoraphobia, or agoraphobia without history of panic disorder.

Specify type:

- **Animal type**
- **Natural environment type** (e.g., heights, storms, water)
- **Blood-injection-injury type**
- **Situational type** (e.g., airplanes, elevators, enclosed places)
- **Other type** (e.g., fear of choking, vomiting, or contracting an illness; in children, fear of loud sounds or costumed characters)


The phobia usually involves something that the patient can and does encounter frequently. He offers rational explanations for his fear, but usually recognizes that these only partially account for his feelings. Nevertheless, although he often perceives his fear to be inappropriate, he feels that avoidance of the phobic situa-
tion is the only reasonable choice in view of his intense fear. The patient will agree that it is irrational to be afraid of the subway, but he is convinced that because he is afraid, he has no alternative but to keep away! The interviewer can often uncover hidden meanings by empathic inquiry concerning the imagined consequences of forcing himself into the phobic situation.

A patient with an overwhelming phobic fear of enclosed spaces such as elevators remembered a frightening experience of being smothered with a pillow by an older sibling while playing on the bed with her. She thought she was going to die and lost control of her bladder. When her sister lifted the pillow from her face she was made fun of the patient for wetting herself. The patient felt humiliated. The murderous aggression, terror, and subsequent shame embodied in this episode became symbolized and encapsulated in her phobia.

Phobic symptoms frequently progress and extend from one situation to another. A woman who is first afraid of buses becomes fearful of crossing streets and finally even hesitates to venture outdoors. A man who is frightened of eating in restaurants overcomes this fear but is then unable to ride on subways. Patients will not readily volunteer the details of their initial symptoms, and it may require many interviews to uncover the fear that precipitated the first episode. Such persistence is worthwhile, because it is in the original context that the major psychodynamics will be exposed. This, of course, accounts for the patient's propensity to obscure the matter.

The typical phobic patient attempts to conquer his fear. As he does so, shifts in symbolization or displacement result in the substitution of new phobias for the old ones. The new symptoms may be less distressing to the patient or may involve more secondary gain, but they are always aimed at avoiding the same basic conflict.

**Phobic Character Traits**

Far more common than the symptomatic phobia is the use of avoidance and inhibition as characterological defenses. This is present in all patients who have phobic symptoms, but it is also widespread in other individuals. The psychodynamics of phobic character traits are similar to those of phobic symptoms. In both, the patient avoids a situation that represents a source of anxiety, but in the phobic character the fear is usually unconscious and the avoidance is explained as a matter of taste or preference. Often, interest or intrigue is mixed with fear, representing the emergence of the forbidden wish, and the patient envies people who can comfortably enter the phobic area. To illustrate, a young
woman who did not like speaking in front of groups envied her husband’s ability to do so and felt that this ability meant that he was totally free of all anxiety. Other patients may be unaware of the neurotic basis of their avoidance, but accompanying symptoms of anxiety will reveal the underlying emotional conflict. An attorney who avoided all athletic activity was a devoted follower of newspaper accounts and television broadcasts of sports events. On occasion he would feel palpitations and faintness during the violent moments of football games. The anxiety that prevented him from participating in his childhood emerged directly when he was a spectator in adult life. If the denial is more extensive, there is simply a lack of interest in the entire area. This is recognized as defensive avoidance only when the person’s life situation exposes his inhibition as maladaptive. For example, a woman living in the center of a large city can explain her inability to drive a car as a reasonable choice, but when she moves to the suburbs and still refuses to drive, the neurotic basis of the preference is exposed.

Phobic traits can be basic to character structure. The individual is preoccupied with security and fears any possible threat to it, constantly imagining himself in situations of danger while pursuing the course of greatest safety. This person is familiar as the man who spends his vacations at home, pursues the same interests, reads the same authors, and works at the same tasks year in and year out. He has a limited number of friends and avoids new experiences.

A common example of phobic character traits is the young woman who is married to an older man. She lives near her mother and speaks to her by telephone several times daily. Her children have also developed phobic symptoms and are excused from school gym classes because of minor physical difficulties. The family members are familiar visitors to their general practitioner’s office. She looks younger than her age and is quite charming with men, although not quite as popular with her female friends. At times she may seem impulsively exhibitionistic as her seductiveness emerges in protected social settings. The man with a similar defensive pattern is more prominently concerned with assertion than with sexuality. His boyishness is often mixed with so much bravado that he may seem more foolhardy than frightened. This defensive assertiveness is more likely to be aimed at a powerful superior than at a peer, and he hopes he will be seen as a self-confident and promising young man but unconsciously does not expect to be seen as an adult.

The phobic individual usually values sexual behavior primarily for the accompanying sense of warmth and security. He is often reluctant to initiate sex, thereby hoping to avoid any responsibility for acting on forbidden impulses.
Differential Diagnosis

Phobic defenses are often seen in patients whose personality types are predominantly obsessive or histrionic. The resulting clinical picture reflects both the phobic avoidance and the more basic character structure. This patient’s conflicts are revealed through exploration of his phobic defenses. He often has no awareness of their content, which basically involves dependency, with admixtures of sexuality or aggression.

The obsessive-phobic individual is most often concerned with the avoidance of aggression. He may be fearful of using knives or driving a car. These fears may extend to symbols of control and power. A successful businessman with a strongly obsessive character refuses to touch any money, a symbol of social power. The obsessive person spends hours ruminating about his phobia, and his constant preoccupation is often more disabling than the actual symptom itself. Every obsessive patient, even if he does not have phobic symptoms, will reveal some characterological inhibitions that involve defensive avoidance. For example, one may see an aversion to competitive sports rather than a symptomatic fear of handling knives or sharp objects. In this case, aggressive impulses are avoided through an inhibition of activity rather than by a neurotic symptom relating to symbols of aggression.

The conflicts of the histrionic patient with phobic defenses are most likely to involve sex or dependency. Symptoms are frequently elaborated and dramatized. It may require many interviews to determine the content of the patient’s phobias. To illustrate, in an initial interview a woman described her fear of walking on the street alone. She denied awareness of what she feared, admitting only that she might become “upset.” Several interviews later, she added that she feared that a man might make sexual advances. Her fear that she might not decline such overtures was only revealed after a year of treatment. The histrionic phobic patient is frightened by her own emotionality and avoids experiences that produce overwhelming emotions. Either her sexual responses are inhibited or her sexual behavior is almost nonexistent. Some fears involve physical sensations that are similar to those of sexual excitement, such as being in a sailboat that is heeling over in the wind.

It is common for several conflicts to be represented symbolically by a single phobia. An agoraphobic woman who insists on being accompanied on the street by her husband avoids sexual temptation, and her husband’s presence also reassures her that he has not been injured and is available to care for her. Her interest in other men and her fears for her husband’s welfare are both related to her repressed anger toward
and dependence on her husband, and this anger is more directly expressed by her excessive demands, which restrict his life as well. Her phobic symptom enables her to obtain gratification of infantile dependent wishes while avoiding direct expression of her sexual and aggressive feelings. The denial and avoidance of these impulses stem from an early fear of the parental disapproval that would result from their recognition and gratification.

Phobic defenses are only partially effective, and the phobic individual continues to experience anxiety. Therefore, phobic patients typically experience the emotional and physical symptoms of anxiety, such as palpitations, dyspnea, dizziness, syncope, sweating, and gastrointestinal distress, depending on how their autonomic nervous system is constituted. These may form the basis for hypochondriacal preoccupation or panic attacks in more severely phobic patients.

The clinician’s reassurance and simple explanation of the psychological basis of these physiological symptoms may seem to be readily accepted by the phobic person. However, he is prone to continue his worries about somatic illnesses and often pursues other medical treatment without telling the clinician. When he obtains evidence of an organic disease, or when some medical treatment leads to improvement, he has further support for his own belief that his problem is really physical and that emotional conflicts are of little importance.

Generalized anxiety disorder is characterized by excessive worry of one form or another that is present most of the time and is difficult to control, leading to impairment of normal life activities. The manifestations of this worry are protean—concerns about health, occupation, social capacities, the possibility of harm occurring to oneself or loved ones, and so on. It has a pervasive, chronic quality unlike the acute attacks of panic disorder or the specificity of phobias, and it permeates everything, making life miserable for the patients and others around them, including the clinician. Major depression coexists in two-thirds of these patients, suggesting a shared biological origin. The clinician must approach these patients empathically and not succumb to the countertransference irritation that their irrational concerns can arouse. The underlying psychodynamics of these patients’ all-encompassing worry often revolve around persistent expectations that they will be found inadequate and irritating, a self-fulfilling prophecy that can be usefully addressed in the transference.

Posttraumatic stress disorder is recognized as a common anxiety disorder. Because of the frequency with which this diagnosis is made, it is addressed in a separate chapter. With regard to differential diagnosis, the key differentiation from the other anxiety disorders revolves
around the historical fact that the patient has been exposed to a traumatic event that was life-threatening to the patient or someone loved and invoked a profound sense of fear, helplessness, or horror.

**Mechanisms of Defense**

**Displacement and symbolization.** For avoidance to be effective, the conflict within the mind of the patient must be displaced to the outside world. The patient shifts his attention from an emotional conflict to the environment in which that conflict occurs. For example, the child who is fearful of competitive relations with his classmates avoids going to gym. More elaborate displacements may be based on symbolic representation. Every mechanism of symbolic representation may be involved, and the interpretation of phobic symptoms is as complex as the interpretation of dreams. Displacement can also be based on some accidental connection between the emotional conflict and a particular place or situation. In most clinical phobias, all of these mechanisms are involved. For example, the fear of subways in young women is often traced to the symbolic sexual significance of the subway, which is a powerful vehicle that travels through a tunnel and vibrates in the darkness.

**Projection.** Phobic avoidance often involves projection as well as displacement and symbolization. The analysis of a subway phobia may first reveal a fear of attack, then a fear of sexual attack, and finally an unconscious fear of loss of control over sexual impulses. The patient's impulses are projected onto the other riders in the subway, and this projection allows the patient to rationalize the fear.

The link between phobic defenses and projection relates to the link between phobic and paranoid traits. Like the paranoid patient, the phobic patient uses relatively primitive defenses, with denial playing a prominent role. He thinks concretely, focuses on the external environment rather than his inner feelings, and keeps secrets from the interviewer. However, in contrast to the paranoid patient, the phobic patient maintains reality testing. He denies the inner world of emotions more than the outer world of perception. The phobic patient displaces his anxiety to the environment and projects his impulses onto others, but rarely onto anyone emotionally important to him. He maintains firm human relationships in order to ensure continued gratification of his dependent needs. Therefore, the initial interviews are conducted with an aura of goodwill. The patient represses his hostile or negative feelings, and he typically has no interest in exploring his inner mental life. He often exhibits an infantile confidence in the clinician's magical ability to alleviate his distress.
Avoidance. The defensive utilization of avoidance is the essential characteristic of the phobic individual. The ancillary defenses of symbolization, displacement, and rationalization serve to make the avoidance possible. Phobic defenses are effective only when anxiety can be confined to a specific situation that the individual is able to avoid so that his psychological conflicts will no longer disturb him. This sequestration of anxiety to an external situation is rarely completely effective, and therefore the phobic individual must also avoid thinking about his internal conflicts. It soon becomes apparent in the interview that a phobic individual does not, cannot, or simply will not discuss certain topics. The central problem in interviewing or treating a phobic patient is to lead him, even at times to urge him, to move into the areas of action in his daily life. The patient must be encouraged to do something that he does not want to do, but the interviewer must not make the patient phobic of the interview itself. This usually means allowing the patient to establish a dependent relationship and then using it to reward him for entering frightening situations.

The phobic patient shows a striking intolerance for anxiety, and it is this fear of anxiety that usually motivates him to seek help. He may be able to avoid the object of his phobia and even avoid thinking of his conflicts, but he is not able to avoid the anticipatory anxiety of what would happen if he were to enter the phobic situation. His usual goal in treatment is to become immune to anxiety, even in circumstances that would frighten anyone. During the treatment, the clinician must inquire not only into what is so frightening about the phobic situation or the forbidden impulses but also into the patient's intolerance of anxiety.

The phobic partner. The patient's fear of anxiety is highly contagious, particularly for other individuals with unconscious phobic tendencies. The partner of the phobic patient, who accompanies her whenever she ventures outdoors or across the street, has accepted the patient's belief that anxiety must be avoided at all costs. If the patient improves with treatment, the partner can become a major obstacle to therapy as his latent phobias become more manifest. The prototype for this role is to be found in the interaction of the overprotective mother and the anxious child. Questions such as "Are you sure she's ready to try it by herself?" are common. The patient will often attempt to enlist the interviewer into the partner role. She does this by dramatizing her anxiety and suggesting that the interviewer's help is all that is needed to conquer the problems. This infantile magical orientation toward treatment may feed the interviewer's omnipotent fantasies, but it only reconstructs the pattern of relationships that created the phobia.
Counterphobic behavior. Counterphobic patterns are an interesting developmental variant in which the patient denies his phobias. His behavior dramatizes his disregard of realistic fears, and it seems to prefer situations in which there is a potential for disastrous consequences. This patient has also displaced his anxiety to these external situations and has symbolized his unconscious fear by mastering the realistic external danger. However, whereas the phobic person then avoids the external situation, the counterphobic individual accepts the realistic danger as a challenge and thus conquers his unconscious fear. Both defensive patterns involve magical thinking. The phobic patient usually selects a situation in which there is mild realistic danger, however slight, and then magically believes that it will certainly happen to him. The counterphobic person selects a setting in which danger is possible, or even probable, but never certain. His magical feeling is, “I am completely in control here, so there is no reason for fear.” The individual who is fearful of asserting himself with women and yet participates in extreme sports is a common example. He enjoys the admiration he receives as being brave, or adventurous, or fearless.

Mixtures of phobic and counterphobic defenses are common, and detailed investigation of counterphobic persons often reveals widespread patterns of inhibition in other areas of life. For example, the same individual who risks life and limb racing cars might be uncomfortable speaking in public. Counterphobic defenses may provide greater secondary gain and social usefulness, and as with all symptoms, it is necessary to separate their adaptive value from their neurotic origins. They may also allow relatively direct gratification of the forbidden impulses, but with little flexibility or spontaneity of behavior. The counterphobic individual rarely seeks help for this pattern, but the daring aspects of his behavior may alarm others.

For example, it would seem totally incongruous that a Navy jet fighter pilot would be afraid of heights. When the incongruity was pointed out, the man replied, “It’s about control. When I land at night on an aircraft carrier, I am in control. I know exactly what I’m going to do and how to do it. I’ve trained to do this.” The interviewer asked, “What about the observation platform on the Empire State Building? Can you look out at the horizon?” The reply was affirmative. “How about looking straight down?” “Forget it” was the answer. The interviewer continued, “Let’s lower the wall down to your knee level.” The man interrupted, “Don’t even go there!” The interviewer continued, “Are you afraid you might be tempted to jump?” The former pilot replied, “That’s it; you’ve got it.” It is difficult to find a more illuminating illustration. Who among us is not awed by the prospect of a night carrier
landing in a jet fighter? Nevertheless, this man had been trained thoroughly in stages and had developed confidence in his self-control in that situation. He had internalized his teachers as part of a professional identity. The roof of a building or a high rock ledge was a different story. Here, his most primitive wish to fly with the ease of a bird was stimulated. His confidence in his ability to control this grandiose wish was not solidified. It is like the dream of young men to fly magically like Superman. Not many older men still have that dream because reality has, over the years, chipped away at their feelings of grandiosity. A survey of some of our psychiatric residents revealed that some of the young women have also had that dream, but they reported much more fear of falling than the feeling of exhilaration described by the male residents.

The Panic Disorder Patient

In panic disorder (Table 8-2), the characteristic attacks, although often brief (usually less than 1 hour, often 5-10 minutes in duration), are intensely disabling. With emergence of the attack, apparently out of nowhere, the individual is overwhelmed by sudden, acute anxiety accompanied by frightening somatic symptoms, such as breathlessness, sweating, rapid heartbeat, shaking, nausea, dizziness, choking, chills, and the terrifying feeling that death is imminent (Table 8-3). Panic attacks tend to be recurrent and often lead to secondary fear of venturing out of the home (agoraphobia) because the person dreads being in a situation that he cannot readily leave if an attack takes place; he thus becomes conditioned to fear the place where the panic attack occurred or places that resemble it.

One of the first descriptions of what would later be called panic disorder is to be found in Freud’s *Studies on Hysteria*. In “The Case of Katharina,” Freud in 1890 described an 18-year-old adolescent with recurrent episodes of acute anxiety accompanied by severe breathlessness. Katharina recounted, “It comes over me all at once. First of all, it’s like something pressing on my eyes. My head gets so heavy, there’s a dreadful buzzing, and I feel so giddy that I almost fall over. Then there’s something crushing my chest so that I can’t get my breath.” She further described, “My throat’s squeezed together as though I were going to choke” and “I always think I’m going to die—I don’t dare to go anywhere; I think all the time someone’s standing behind me and going to catch hold of me all at once.” In a penetrating interview (by modern standards, perhaps too “penetrating”), Freud quickly established that the onset of her disorder was precipitated by sexual advances that had been made by her father when she was 14 years old. The symptoms—the
TABLE 8-2. DSM-IV-TR diagnostic criteria for panic disorder

A. Both (1) and (2):
   (1) recurrent unexpected panic attacks
   (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
      (a) persistent concern about having additional attacks
      (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
      (c) a significant change in behavior related to the attacks

B. Absence of agoraphobia

C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).


Donald Klein’s pharmacological treatment studies in the 1960s led to the modern delineation of panic disorder as a clinical entity distinct from generalized anxiety disorder. Klein used tricyclic antidepressants in the treatment of panic disorder and agoraphobia with considerable success. The symptoms of acute panic, with its palpitations, sweating, trembling, dyspnea, fear of imminent death, and so on, and secondary inhibitory agoraphobia were often effectively interrupted and prevented by this pharmacological intervention. This therapeutic discovery spawned considerable important clinical research into the biological nature of the anxiety disorders and their possible genetic relationship to depressive disorders. (Two-thirds of panic disorder patients...
TABLE 8-3. DSM-IV-TR criteria for panic attack

Note: A panic attack is not a codable disorder. Code the specific diagnosis in which the panic attack occurs (e.g., 300.21 panic disorder with agoraphobia).

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feeling of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, light-headed, or faint
9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. fear of losing control or going crazy
11. fear of dying
12. paresthesias (numbness or tingling sensations)
13. chills or hot flushes


experience an episode of major depression in their lifetimes.) Klein posited a theory of exaggerated separation anxiety as the psychological core of panic disorder.

Developmental Psychodynamics of Phobia and Panic Disorder

Phobic symptoms are universal in children. In fact, although initially they are frequently denied, the existence of childhood phobias will eventually emerge in the history of almost every neurotic patient. The widespread phobic symptoms of children no doubt reflect the normal tendency toward primitive and magical thought in the developing child.

Very young children show definite tendencies toward risk taking or harm avoidance. The terms inhibited and uninhibited to the unfamiliar have been used by developmental psychologists to distinguish these
two groups of children. These behavioral patterns correlate with the high-reactive and low-reactive temperamental dispositions identified in 4-month-old infants. The high-reactive infants were more likely to become shy and timid children. The low-reactive infants were more risk-taking and sociable and less disturbed by the unfamiliar. These studies indicate genetic factors that predispose one to problems with anxiety, risk, and danger and to individualized views of what constitutes safety.

Anxiety in the appropriate context is a universal signal of external danger. The first external danger in life is the presence of a person who is not the “mothering” person. Infants vary enormously in this degree of stranger anxiety. Next, when a healthy bond is established with the mothering person(s), the stage is set for separation anxiety. This, too, serves a major adaptive role because it protects the young child from wandering out of the sight and sound of the mother. This mechanism can be observed in a family of ducks in a pond. The little ducks follow the mother in an order that is established soon after hatching and is maintained. The last one in line has the greatest chance of being eaten. This metaphor applies to human young as well.

The situation is further complicated by the development of a sense of self early in childhood. Through interaction with caregiving, loving parental figures, the developing self learns that some behaviors please the caregivers, whereas others displease them. The child learns to conceal displeasing behavior by not doing it when the caregivers are present. The caregivers discover this and express disapproval. This is the essential paradigm for beginning to internalize parental values. When the wish to obey and win love supersedes the wish to defy to the degree that the child loses his conscious awareness of the latter, we speak of repression. The stage is now set in children with an appropriate predisposition to develop an anxiety of their own forbidden impulses and wishes, which still exist at an unconscious level.

The phobic individual learns as a child that the world is a frightening and unpredictable place. His parents may reinforce this view through either their timidity or their explosive or violent outbursts. In some families, the mother is herself somewhat phobic, and the father is unpredictable, irritable, and angry. This is a not uncommon story in the history of the patient who may later develop posttraumatic stress disorder in response to a real-life trauma. The whole family is frightened of the father’s episodes and tries to avoid them. Other patterns are common; for example, the father may share the mother’s fearfulness, and the threat of aggression may come from outside the family circle. There is an important difference between the typical childhood experiences of the paranoid patient and those of the phobic patient. Both involve the
fear of rage and even violence, but the family of the phobic patient offers some hope of safety, so that the child develops a sense of potential security, although at the price of anxiety and diminished self-confidence. In contrast, the paranoid person learned that the only security from external dangers that his family could provide involved a total loss of the sense of identity and that his only chance for both independence and safety resided in constant lonely vigilance.

The phobic person overestimates both the dangers of the outside world and the inner emotional danger of anxiety. Often the fears of outer dangers have been learned directly from his parents. At times these may be reinforced by actual increases in danger, either because the child is vulnerable, as in the chronically ill, or because the family lives in a setting that presents realistic dangers. The exaggerated fear of anxiety is related to the mother's inability to perceive her child's emotional state and her consequent defensive overprotection. The infant needs both adequate exposure to external stimuli and protection from overstimulation. The appropriate balance between these is a function of the mother's sensitivity to her child's signals of distress. If she responds indiscriminately as though all signals mean distress, the child does not have an opportunity to develop a normal tolerance for anxiety. In other words, the mother's anxiety and consequent difficulty in responding to the child can lead to the later development of intolerance to anxiety in that child.

The mother's insensitivity to and overevaluation of the child's anxiety continue throughout the subsequent stages of development. She responds to the child's normal separation anxiety by refusing to allow him out of her sight, she handles his stranger anxiety by limiting his contacts with new people, and she teaches him to deny sexual or aggressive impulses that may lead to conflict with his parents or with his developing superego. At each stage of development, the child fails to conquer his anxiety and must learn to deal with it in some other way. He identifies not only with his parents' fears of the world but also with their unusual sensitivity to fear and their mode of coping with it. This is seen most clearly in school phobias in which the mother's separation anxiety is at least as great as that of the child.

The developmental history of the phobic patient typically reveals that he was afraid of the dark, of being alone in his bedroom at night, of nightmares and demons. The door to his room was left open or his light was left on. He was comforted by these reassurances that his family was close at hand. His parents emphasized the dangers of traffic in the street, bullies on the playground, evil men lurking in the park, or the hand of fate in the form of terrible illness. He was warned never to cross
the street or to ride his bike after dark, although his peers had long en-
gaged in these activities. Parental prophesies about bullies were accu-
rate, because his timidity provoked bullying behavior from his class-
mates. If he did not want to go to camp or became frightened of school,
his family reacted to these fears by allowing him to avoid the situations
that caused them.

The phobic patient frequently utilized one of his parents as a partner
during his childhood. By agreeing to accompany and protect the child
and thus mitigate his separation anxiety, the parent not only encour-
aged the development of phobic defenses but also revealed his own
underlying phobic character. The child was led to feel that his own
adaptive skills were inadequate and that magical reliance on his parent
would somehow help to compensate for this. If he was helpless, his par-
ents might be able to protect him.

The panic disorder patient often has a history of traumatic child-
hood experiences based both on their constitutional vulnerability and
on family environment. Normal separation anxiety is not well toler-
ated. This may reflect a biologically based low threshold for an inborn
fear response to the unfamiliar, with an accompanying high autonomic
arousal. Simultaneously, actual frightening behavior by a parent or
caretaker may lead to insecure attachment and a chronically impaired
sense of safety. The combination of these two, constitutional and envi-
ronmental, may lead to an avoidance of situations that are unfamiliar
and could be mastered by experience, particularly in the presence of a
comfortable, calm, reassuring parent. One psychodynamic theory of
panic attacks posits that threats to attachment in adulthood trigger re-
gression to the childhood experience and become physiologically man-
ifest in the autonomic fear reaction of the panic attack.

The combination of little self-confidence, low toleration for anxiety,
a dependent mode of adaptation, a tendency for magical thinking, early
exposure to models who use phobic defenses, and the use of symptoms
and suffering as a means of dealing with authorities leads to the devel-

dopment of the phobic character

MANAGEMENT OF THE INTERVIEW

The phobic and panic disorder patient relates easily during the initial
portion of the interview. He comes seeking relief and is polite and eager
to talk about his problems. Silence and resistance arise later in the inter-
view, but the opening moments are marked by an aura of goodwill. As
the interview progresses, it becomes apparent that the patient's agree-
ablleness continues only if the interviewer cooperates with the patient’s defenses—that is, if he helps the patient avoid anxiety by not pursuing certain topics and by offering magical protection. The task of the interviewer is to direct the discussion into these forbidden areas but at the same time to maintain the rapport necessary to sustain the relationship through the painful exploration of the patient’s psychological problems.

**Early Cooperation**

The phobic patient is frequently accompanied to the first appointment. He may come with a member of his family or with a friend. If he comes alone, he often expects to be picked up afterward, or his companion is waiting in the car. If the interviewer has reason to suspect that the patient is phobic, it is advisable to see the patient alone, speaking to his companion only afterward, if at all. If the diagnosis is not apparent until both are in the clinician’s office, the clinician should use the first convenient opportunity to tactfully dismiss the companion in order to speak with the patient alone. The companion’s presence protects the patient from anxiety by inhibiting thoughts and feelings that are disturbing. Because the clinician wants to explore these thoughts and feelings, he is more likely to be successful if the companion is not present. There is no purpose in interpreting the defense at this point, and a simple “Could you wait outside while I speak with your brother?” or “Can we talk alone while your husband waits outside?” will suffice. The request should be addressed to the individual who the interviewer senses is least likely to object.

Some phobic patients have an almost exhibitionistic eagerness to relate their distress and describe their inability to overcome irrational fears. Others are more ashamed of their problems and may conceal their symptoms. The interviewer will learn to recognize the latter group by the overt anxiety and the extensive use of avoidance in the patient’s life and in the interview itself. Whether the patient presents his symptoms as a chief complaint or reveals them only reluctantly, he is more eager to obtain the clinician’s reassurance than to investigate his own emotional life. The interviewer, however, wants to discuss the patient’s problems and symptoms and thereby gain some understanding of the patient’s psychological conflicts. In view of these discrepant goals, the natural starting point for the interview is a discussion of the symptoms.

Early in the interview the patient may ask, “Will you be able to help me?” The timing of the question suggests that it is a request for magical reassurance. The interviewer can use this as a lever to initiate a more thorough investigation of the problems, replying, “I can’t give you an
answer to that until you've told me more about yourself." He offers the promise of future help in return for enduring present anxiety. Although many patients experience relief from simply talking about their problems, this process makes the phobic patient more anxious. He needs a direct promise of the benefit before he will participate in the treatment process.

**Exploration of the Symptoms**

The problems encountered in interviewing a phobic or panic disorder patient are often encapsulated in the exploration of his symptoms. (Obsessive and histrionic patients also have symptoms, but their discussion is seldom a central focus of resistance, although the obsessive-compulsive disorder patient often conceals his symptoms.) The phobic patient responds differently. His characteristic defenses often emerge in the discussion of his symptom, just as they did in its formation. When the interviewer tries to talk about the patient's behavior, the patient shifts the discussion to a neutral topic or asks the clinician for help while avoiding exposure of his problems. His displacement of inner conflicts to the outside world may appear as a concentration on the external world rather than his inner feelings.

His symptoms are associated with considerable anxiety, and some phobic patients offer them as the chief complaint or mention them early in the interview. The clinician asks for a detailed description of the symptoms, the situations that evoke them, the history of their development, and the therapeutic measures that the patient has attempted on his own behalf before coming to the initial interview.

In an initial interview, a single 30-year-old professional woman described the onset of her panic attacks: "It was so bizarre. It first occurred during my lunch break 10 days ago. I went into a deli to buy a sandwich. The store was crowded, and I had to wait in a long line. I suddenly felt extremely anxious and became cold and clammy." The interviewer asked how she was passing the time as she waited in line:

Now I remember: I was reading a story in a newspaper about a woman who stabbed her boyfriend. My heart started to race. I thought to myself, "I'm having a heart attack. I have to get out of here." I fled into the street, called my office on my cell phone, and told them I was sick and had to go home. I raced back to my apartment, closed the blinds, popped a Valium, and lay down on my bed. That helped, but I continued to feel this sense of dread. I've gone back to work, but it hasn't been easy. My office is on the 35th floor, and now the elevator scares the shit out of me. I can't get in if it's crowded. Sometimes I think I'm going
crazy. I've been to see my internist. He said I'm in perfect health, but I'm not; I'm on the edge of a nervous breakdown.

The interviewer clarified what she was experiencing: a psychological disorder expressing itself through frightening physical symptoms. Naming what she had experienced—a panic disorder—and indicating that it was treatable had a calming effect.

Such delineation of the illness is an important part of any clinical interview. Telling the patient that the syndrome is clinically recognized, that many people have it, and that it is treatable is a therapeutic intervention that diminishes anxiety. Anxiety is exacerbated by the patient's feeling that the experience is outside the realm of human knowledge and is incomprehensible.

The same patient had a successful career in the financial world and was ambitious and hardworking. She had broken up with her boyfriend 2 weeks before the onset of her symptoms over his refusal to get engaged. The interviewer asked about this relationship. "What is he like? How did you relate to one another? What were your similarities and differences?" This inquiry revealed that she had been unusually dependent on him to make decisions, such as where they would go on vacation and how they would spend their weekends. Given the patient's forthright and independent attitude in her professional life, her constant deferral to her boyfriend seemed paradoxical.

Such a story is not uncommon in the panic disorder patient and speaks to the underlying discomfort that many such patients possess concerning their assertive strivings in intimate relationships.

The patient's father was described by her as a frightening figure during her childhood. He was irascible and frequently lost his temper. She characterized her mother as "infantile": "She always acted like a little girl who needed to be taken care of and pampered. She wasn't too good at taking care of me. I'm not sure she should have been a mother." As a child, the patient was shy, fearful, and constantly worried. Separation issues were a problem during her early development. She had difficulty when her mother left her at school and had to come home from summer camp because she was inconsolably homesick.

The interviewer asked about her feelings concerning her boyfriend's reluctance to commit to the relationship and its subsequent breakup. "I was furious. I wanted to kill him. I don't tolerate anger well. It frightens me. Then I feel guilty. At the same time I felt so alone. I needed him. That weakness made me feel more angry. It was a vicious cycle. I became depressed, guilty, and angry." This productive interchange allowed the interviewer to explore her fear of anger and its connection to the childhood anxiety that her father's outbursts had engendered. She continued, "I feel so insecure when I'm alone and not in a relationship."
I'm not even sure the actual person is so important. I just need someone there to make me feel comfortable. Sort of pathetic isn't it?" This confession enabled the interviewer to explore her insecure attachment to her mother, whom she had experienced as more like a demanding sibling than a protective and comforting parent, and her childhood desire for someone she could count on to comfort her and relieve her anxieties and worries. These themes, combined with the appropriate use of medication, were further explored and developed in the therapy and led to a successful treatment.

Unraveling the Details

The interviewer listens to every aspect of the patient's description of his symptoms in order to understand their psychological significance. For example, one woman who is afraid of crowds may emphasize her concern about the people "who brush against me," whereas another will speak of her feelings of being "alone in the midst of strangers." The first description would suggest concern about sexual feelings; the second connotes anxiety over separation from the sources of dependency gratification. Of course, the interviewer would not interpret this to the patient until later in the treatment.

The consequences that a patient fears, were he to enter the phobic situation, may involve the projection of a repressed wish or the fear of its expression and the retaliation that would ensue. The patient may be able to elaborate detailed fantasies of what he fears, with no awareness that he is describing an unconscious wish. This is valuable information for the clinician, but again, it should not be shared with the patient early in treatment. For example, a woman who was afraid to go out on the streets was able to portray in some detail the sexual events she feared. However, it was many months before she was aware of her own sexual desires. The phobic symptom represents the unconscious fear far more clearly than the forbidden wish.

A woman described her fear of restaurants, and the clinician inquired, "What would happen if you did go into a restaurant?" The patient replied, "I would get upset," expecting the interviewer to stop at this point. Instead he asked, "And what would happen if you did get upset?" The patient was surprised and answered with annoyance, "I might faint and have to be carried out on a stretcher." The interviewer continued, "And what if that happened?" Now the patient felt justified in her anger, and she replied, "How would you like to be carried out on a stretcher?" The interviewer answered, "We both know that you have a dread of such a situation that is different from the distaste that the predicament would hold for others, and I would like to help you with it." The patient relaxed, saying, "Well, my dress might come up—people
might notice the rash on my legs, or they might say, 'Look at that one; she must be on her way to the mental hospital.'"

The interviewer had uncovered the patient's fear of going crazy as well as her shame about her appearance. Further exploration revealed a mixture of exhibitionistic and aggressive impulses, and her self-punitive need to be controlled and humiliated in retaliation for them.

The Initial Episode

The initial episode of the symptom is particularly enlightening. A middle-aged woman who was afraid of eating meat could offer no explanation for this behavior but was able to recall that it had first occurred at the dinner table during an argument between her husband and daughter. She later revealed that a frequent battle in her childhood centered on the religious proscription against eating meat on Fridays. The symptom was related to her fear of the open display of defiant aggression both in her current life and in her childhood.

Physiological Symptoms

In describing their symptoms, some phobic and panic disorder patients discuss their subjective sense of anxiety, whereas others, utilizing more extensive denial, emphasize the physiological concomitants of anxiety, such as trembling, palpitations, or chest pain. The interviewer can lay the groundwork for future interpretations by linking these physical responses to the appropriate subjective states. He might say, "When you get giddy and feel faint, there must be something frightening you," or "That tightness in your chest is the kind of feeling people get when they are anxious." Some individuals experience anxiety as a diffuse bodily sensation that borders on depersonalization. If hyperventilation plays an important role in the production of symptoms, the patient may loosen his collar, complain that the room is stuffy, or ask to have the window opened. Now the interviewer makes a difficult choice. If he remains quiet, the patient will likely feel he is insensitive to the complaint. On the other hand, if he accommodates the patient, the patient will expect more indulgence. If the room is indeed stuffy, there is no harm in opening the window. The chances are that the patient was reacting to a topic under discussion. By opening the window and continuing the exploration of the uncomfortable topic, he has an opportunity to ask, "Do you feel better now?"—but only if the patient continues the discussion. The phobic patient might ask, "Can't we talk about something else?" or an equivalent. Now the interviewer can comment, "Perhaps there is something inside you that made the room feel stuffy, something that this topic has triggered." This exchange typifies the continuing negoti-
A common physiological manifestation of anxiety, which the phobic patient tries to ignore, is the gurgling of his stomach. When this occurs during the interview and the patient reacts with discomfort, the interviewer can remark, "It seems as though you're embarrassed about the noises your body makes." This indicates that the interviewer is comfortable discussing such matters and that the patient's feelings about his body are an appropriate topic for the interview.

Identification

If the patient has ever known anyone with a similar symptom, the exploration of this relationship can offer further insight. Phobic patients frequently employ relatively primitive modes of identification, and phobic symptoms are often based on a specific model. It is unusual not to uncover a phobic parent or grandparent or some other individual who offered a phobic pattern with which the patient could identify. Furthermore, the patient usually has great empathy for other phobic persons and may have surprising insight into the dynamic significance of the other person's symptom, although he is quite unable to see the same mechanism in his own behavior.

Changes in the Symptoms

It is revealing for the interviewer to detail the shifts and developments in the history of the symptoms. A specific conflict that is difficult to identify in any given symptom becomes obvious when this historical pattern is viewed as a whole. For example, a man presented a fear of eating in restaurants. When more details were elicited, he revealed that this was a recent symptom and that previously he had been afraid of flying. The history soon revealed a long string of apparently unconnected phobic symptoms, all of which occurred in situations in which he was out of contact with his mother. He had counterphobically refused to give her his cell phone number because "She's so intrusive." He harbored great unconscious resentment of his mother, and his aggressive impulses toward her were manifested by a fantasy that she would become ill and be unable to contact him. His resulting guilt and anxiety were controlled by the phobic symptoms.

Avoidance

The Patient's Sensing of Danger

At some point, the interview progresses to a more general discussion of the patient's life. The interviewer may ask, "What are your other wor-
ries?" or inquire into the patient's mode of dealing with problems in his life. The patient is skillful at shifting the topic to comfortable subjects, and the interviewer's task is to frame the questions so that the patient cannot escape dealing with the real issues. When this is successful, the avoidance mechanism will be seen in its purest form as the patient says, "I'd rather not talk about that"; "That is very upsetting to me"; or "Can we change the subject?" This is a critical point in the interview, for it allows the interviewer to establish that anxiety is not a valid reason for avoidance. He can reply, "I appreciate that it is difficult for you, but I know that you want help, so let's go ahead and see what we can do," or "Try to do the best you can. I will try to make it easier." In this way, he bargains with the patient, withholding the promise of help until the patient is willing to move into the phobic area, at least in his thinking.

It is difficult to provide the needed reassurance and at the same time to avoid condescension or the suggestion that the patient is an infant. However, with sicker or more dependent patients, the interviewer's direct assurance of protection from anxiety may be necessary: "I've treated other patients with this symptom, and I don't think that any harm will come to you." This is a magical maneuver, and it encourages a dependency adaptation on the part of the patient. It allows the patient to establish a positive transference that facilitates the treatment. The complications are dealt with later, but with a severely phobic patient the exchange of avoidance for magical dependency may represent a major improvement.

The Patient's Search for Treatment

Phobic patients actively seek treatment. They consider it a form of insurance and may collect therapies and remedies in the same way that other people collect insurance policies. There is a feeling of security that stems from having a therapist, and it is this security, rather than therapeudic effect, that seems to motivate the patient's search.

Often the patient conceals his treatment from others, and it is helpful to ask the phobic patient who knows that he is seeing a mental health practitioner. He may feel that he will get more support and reassurance from other people if they are not aware that a therapist is caring for him. He does not trust the clinician to provide adequate assistance and therefore feels safer if he is able to keep other channels open. At times this patient may see two clinicians simultaneously, keeping one a secret from the other. Hence a careful exploration of the patient's prior and current attempts to seek psychiatric help is critical. The patient may already be taking medication prescribed by another clinician, and this
may only emerge when the interviewer broaches the subject of psychopharmacological treatment. The patient may experience guilt over this dual treatment. The clinician can then ask, “Were you afraid that I would be offended if you preferred another doctor’s prescription?”

Phobic patients try to treat themselves. They develop magical rituals that partially alleviate their difficulties, and they frequently conceal these from the clinician until they find out whether his “magic” is an adequate substitute. It is necessary to systematically but sympathetically explore the treatment techniques that the patient has utilized before coming to treatment. Useful questions include “What do you do when you get anxious?”

The patient’s self-treatment often involves the substitution of one phobia for another, trying to maximize secondary gain and minimize realistic inconvenience and secondary pain but still defending himself from anxiety. He may report with great pride that he has forced himself to ride in an airplane, provided it is a short flight, or to go out in crowds, as long as it is not at night. By bargaining with himself in this way, he achieves a subjective sense of trying to deal with his problems while continuing to avoid their psychological roots.

The issue of the clinician’s vacation often presents a dilemma with the phobic patient who in response to this upcoming separation may request medication if it has not previously been prescribed. The contemporary psychiatrist has generally given a phobic or panic disorder patient medication well before an impending break in the treatment. Such a decision should be made early in the treatment and not in response to the patient’s anxiety about an impending separation during which there will be no opportunity to monitor the drug’s therapeutic impact and possible side effects.

Secondary Gain

The secondary gain is important to the interviewer because it aids in understanding the patient’s psychodynamics and because it provides one of the strongest resistances to change. The interviewer can ask, “What can’t you do because of your symptoms?” This may seem to be a blunt inquiry into an aspect of his psychological function, but there is usually sufficient denial that the patient has no awareness that the answer reveals emotional conflicts. Other useful questions include “What is the effect on your family if you are unable to go outdoors? or “How do you manage to get things done if you can’t take the subway?” The patient often reveals discomfort in describing the impositions that he makes on his family and friends. The interviewer can use this oppor-
tunity to sympathize with the embarrassed portion of the patient’s mature ego.

For example, with a woman who reveals discomfort while describing her need to be accompanied to the neighborhood store by her husband, the interviewer can comment, “You are unhappy about asking him to go with you.” The patient will respond either with further expression of her guilt or with an attack on her husband for his exploitation of her dependency on him, thereby justifying her own behavior. In either event, the comment has led to a shift from a discussion of the overt behavior to its emotional significance. It is true that the symptom may reflect hostility toward her husband, but this is too strongly repressed to be interpreted in an initial interview. It is more useful to reinforce the patient’s conscious unhappiness with the secondary effects of her symptoms. This also avoids repeating the struggles with friends and family that every phobic patient has had before he comes to the clinician and begins to cement an alliance between the therapist and the healthy portion of the patient’s ego.

Those social acquaintances who recognize a psychological basis for the patient’s difficulties usually interpret the secondary gain as providing the basic motivation. Their view is that the patient is manipulating his environment in order to obtain certain benefits. The patient responds with injured indignation, feeling that he is accused of enjoying painful symptoms over which he has no control. The interviewer can avoid this unfortunate struggle by maintaining his position of neutral inquirer into the patient’s behavior, attempting to understand rather than to judge it. For example, if a patient’s family thinks that she acts frightened of going outside in order to avoid her responsibilities, the interviewer can ask, “How do you feel when they say things like that?” If she reveals anger, he can support it, and if she denies it, he can give her permission to express her feelings by commenting, “It must be annoying to be blamed for something over which you have no control.”

Avoidance in the Interview

The defensive avoidance that characterizes the phobic symptom is also a critical resistance in the interview. It may appear as an inadvertent omission, a tendency to steer the conversation away from certain subjects, a request for permission not to talk about uncomfortable topics, or an outright refusal to speak. This patient frequently omits crucial data about important areas of his life and then denies responsibilities for this omission. A phobic Caucasian woman spoke at great length about her plans for marriage, but only inadvertently revealed that her fiancé was
Asian. She explained, “You never asked me about that,” a characteristic phobic response. The interviewer replied, “Did you think I might have something to say about it?” He thus addressed himself to the avoidance behind the patient’s denial. Another patient, a young psychologist with phobic character traits, first revealed that he had congenital heart disease when, after months of treatment, the therapist pursued a reference to his scar. The patient explained that the scar resulted from a childhood surgical procedure to correct the defect. The surprised therapist inquired, “Why have we never discussed this before?” The patient explained, “I didn’t realize that it had any psychological significance.” The interviewer responded with a direct confrontation, “It is hard for me to accept that, with your training, you could think that such a childhood experience was unimportant.”

**PRINCIPLES OF TREATMENT**

**The Need for Reassurance**

After relating his difficulties, the phobic patient will seek reassurance. He may ask, “Do you think you can help me?” or “Is there any hope?” Other patients may seek the same reassurance more indirectly, asking, “Have you ever treated any cases like mine?” The interviewer translates the meaning by responding, “I guess you wonder if I’ll be able to help you.” The phrasing of the patient’s question has prognostic significance; the patient who is more optimistic and who expects to play an active role in his own treatment has a more favorable prognosis.

The clinician can reply to these requests for reassurance by saying, “The more we talk about your problems, the more I will be able to help you deal with them.” This answer shifts some responsibility for the cure to the patient while offering the clinician’s assistance and indicating the first step that the patient must take.

The phobic or panic disorder patient also characteristically asks, “Am I going crazy?” His fear of anxiety leads him to perceive his symptoms as evidence of total emotional collapse, with the loss of all control over his impulses. He wants the clinician to take over, to tell him that he is not going crazy, and to assume the responsibility for his emotional controls. The question about going crazy provides an opportunity for exploring the content of the patient’s fear. The interviewer asks, “What do you mean, crazy?” or “What do you think it would be like to be crazy?” He can further inquire whether the patient ever knew anyone who was crazy, and, if so, how that person behaved. Finally, he can
offer reassurance coupled with an initial interpretation of the patient’s inner psychological conflicts: “You must be frightened about the feelings you have bottled up inside. You’ve never lost control in the past, so why should it happen now?”

Often the patient will not be reassured by the content of what the clinician says, but he will detect the clinician’s calm and lack of anxiety. Phobic patients frequently try to provoke anxiety in others, particularly in parental surrogates such as mental health practitioners. The way in which the clinician handles his own anxiety and his attitude toward his patients will serve as a model for the patient and, particularly in early interviews, is more important than any interpretation of the patient’s behavior.

**Educating the Patient**

The phobic patient avoids far more than he is aware of, and one goal of the early interview is to explore the scope of the avoidance and to educate the patient about it. The initial interventions are aimed not at providing the patient with insight into his symptoms but at expanding awareness of his neurotic inhibitions. The therapist might comment, “It is striking that you haven’t said anything about the sexual aspects of your marriage” or “Do you ever feel angry at anyone?” The patient will probably reply that he has no problems in these areas, that he has nothing to say about them, or that this has no bearing on his symptoms, but the groundwork for future interpretations is established.

One goal of treatment is to facilitate understanding of anxiety. Phobic patients often think that other people do not experience anxiety, and their goal is to become immune from it themselves. Early attempts to interpret this are bound to be superficial and ineffective. In time, the interviewer can indicate that anxiety is a normal emotion and that the patient’s anxiety is often appropriate, but only disproportionate to the stimuli that trigger it. Frequently it is the patient’s fear of future anxiety (so-called anticipatory anxiety) that is the major problem.

Questions concerning the patient’s perception of other people’s reactions are useful in increasing the patient’s knowledge about anxiety. After a patient reported a panic attack following a “near miss” accident in which a friend was driving, the interviewer asked, “How did your friend feel at the time?” The patient answered, “He was a little upset, but not as upset as I.” This provided an opportunity to explore the patient’s overevaluation of his anxiety and the fact that his responses were qualitatively similar to those of others. The interviewer replied, “Could it be that you were just more aware of your own feelings than you were
of his, and you were not in control of the car?” The patient answered, “No! He doesn’t feel like I did. He isn’t afraid of fainting or having a heart attack or feeling ‘way out.’” The interviewer then said, “It sounds as if you and your friend were afraid of different things, and his anxiety was only related to the danger and the potential accident.” This provided an avenue for the exploration of the unconscious determinants of the patient’s fear. The issue involved control and who almost lost it. If he had been driving he would have felt to blame. Because he was not, he felt he was risking his life with someone else in control. He had experienced similar feelings as a child with his mother, feeling he needed her for his safety but recognizing that she was also sometimes reckless, which made him feel in danger.

The phobic patient often needs assistance in recognizing his emotions. This has already been discussed in relation to anxiety, but it is also true of other feelings. Feelings are replaced by symptoms, and in time the clinician will learn the pattern this follows. When the patient describes a headache, the clinician can point out, “The last few times you complained about a headache, you were angry at someone. Are you angry now?”

**Medication**

The appropriate use of medication is a crucial component in the effective treatment of the phobic or panic disorder patient. As with the depressed patient, the combination of psychopharmacological treatment and psychotherapy is therapeutically synergistic in the anxiety disorder patient.

The psychological meaning of medication with any patient should never be ignored. This is especially true with the anxious-phobic patient. The patient does not just want a pill; he wants assurance that the clinician has powerful magic that offers protection from anxiety and can provide safety and security. Paradoxically, some patients are reluctant to consider medication even when it is clearly indicated. “It is such a sign of weakness. I don’t want drugs,” asserted a phobic patient when the clinician said that medication was an important part of the treatment. Exploration of this issue led to an uncovering of an aspect of the patient’s childhood experience: “My mother was always popping pills or drinking when she was upset. I don’t want to be like her.” The clinician was able to point out that the appropriate use of medication for her condition did not mean that she would turn into her mother or that she would become dependent on drugs. He clarified that medication would dampen her anxiety and facilitate her ability to achieve mastery of her phobic fears. He commented, “We will explore their psychological
meaning together, and the use of medication will help us to do that. Overwhelming anxiety, like pain, is disabling and dominates your mental world. We have to reduce its intensity so that we can address its psychological origins." This intervention enabled the patient to accept the use of medication, which, after psychotherapeutic work, she was ultimately able to dispense with, although she kept an unfilled prescription in her handbag as a reassuring talisman.

The Role of Interpretation

The early activity of the interviewer is aimed at encouraging the patient to tell his story, to describe the details of his symptoms, and to discuss his personal life. The patient does not want to talk about his sexual, aggressive, dependent, or competitive feelings, but it is important that he be urged to do so. The interviewer demonstrates that he is not phobic in these areas of life and that he expects the patient to follow his lead.

In these early phases of contact, it is seldom helpful to challenge the patient’s avoidance in the outside world, but the clinician quickly interprets the avoidance that appears in the interview, such as the omission of important material or the refusal to discuss some area of life. Premature direct suggestions or interpretations concerning the psychological meaning of a phobic symptom will increase the patient’s defensiveness and interfere with the interview. The interviewer characteristically understands far more than he interprets to the phobic patient.

When a phobic symptom or panic attack is analyzed, anxiety and avoidance are discussed before symbolization or displacement. The patient must first realize that he is anxious and that he avoids the source of his anxiety before he can begin to explore the conflicts that underlie it. Projection is usually interpreted after the other defenses have been thoroughly analyzed.

The specific secondary gains associated with the patient’s symptoms may offer clues as to what type of bargain will be most effective in getting the patient to relinquish his phobia. In time, the clinician will offer to replace these secondary gains but will require as a precondition that the patient enter the feared area. Medication, magical reassurance, and supportive interest and concern can be used as substitutes for the secondary gratifications that the patient obtains from his symptoms. For example, if the secondary gain involves the gratification of dependency needs, the clinician may develop a relationship in which the patient can obtain this gratification within the transference. The clinician can also support the direct expression of the patient’s aggressive feelings, particularly when they occur without the rationalization pro-
vided by the symptom. For example, when the patient becomes angry and then makes a guilty apology, the therapist could say, “You seem to feel that you don’t have the right to get angry” or “Aren’t you allowed to feel angry?”

The bargaining aspect of treatment occurs when it is necessary to associate the therapist’s support and gratification explicitly with the patient’s relinquishing his symptom. Needless to say, this is a technique that is employed only after extensive treatment. An example occurred when a phobic man arrived for his session and stated, “I know I won’t be able to talk about anything today; I’m just too anxious.” The therapist, who knew from previous experience that the man meant what he said, smiled and replied, “Well, shall we stop now?” The patient became quite angry, but he did not want to leave, so he was forced to talk about his feelings.

When the phobic patient seeks help from others, he often seeks rules for life, formulae that will serve as safeguards against anxiety. This emerges in the psychiatric interview as an interest in general formulations that suggest guides for conduct without involving the details of his life. The phobic patient will ask if he needs more rest or suggest that his trouble is that he worries too much. He wonders if he should just take it easy and clings to any suggestion from the clinician in this area. The clinician can reply to these requests by interpreting the patient’s avoidance. He can say, “I guess that you don’t like the idea that your symptoms are related to your own thoughts and feelings.” On other occasions the patient may ask, “Do you think I should try to take the subway?” The therapist could reply, “Are you wondering whether I’ll push you before you’re ready?”

After the meaning of a phobic symptom or panic attack has been explored in detail, it still may seem necessary for the clinician to play an active role in encouraging the patient to enter the feared situation. However, this clinical problem may represent the patient’s fear of assuming the responsibility for acting on his new insight—in a sense, he is phobic of giving up his phobia. He is fearful of the new and unknown feelings and also of the mature adult role involved in deciding to make a major change in his behavior. Frequently, the patient will accuse the clinician of becoming impatient or fed up with him, projecting his own self-contempt onto the therapist. The clinician now shifts from analyzing the dynamics of the specific symptom to discussing the transference relationship and the patient’s attempt to avoid any personal responsibility for his own improvement by attributing it to the clinician’s power. If this is successful, the clinician’s active intervention may no longer be necessary.
Depression

Phobic patients often become depressed during treatment. They fear that giving up their symptoms will necessitate relinquishing infantile dependency gratifications. Depression may be a sign that treatment is progressing, and the therapist should provide the support and encouragement that the patient needs at this phase. It is often a critical point in treatment, because the patient is not asking the clinician to protect him from imagined danger but to help him with the problems he has when he faces the real world.

One of us treated a middle-aged woman who happened to be a trustee of the hospital where he worked. Her worries focused on her own health (she was healthy) and the health of those she loved. She visited multiple specialists and enjoyed the status of "the special patient." She began a session by discussing a friend whom she described as "fortunate" because of her devout religious faith, and she expressed envy for the sense of security that it provided her friend. "I wish I had something like that to comfort me in my moments of insecurity." The psychiatrist replied, "You have something similar in your belief system that provides you comfort; it is medicine, and you have surrounded yourself with highly qualified physicians who represent a team in which you have placed your trust and faith. You endow them with great power, and you are inclined to see them as omniscient. Like most religious persons, you occasionally question their power to help you."

The patient listened intently and appeared mesmerized, gently turning her head from side to side in amazement. She said, "It is so obvious; it's been there right in front of my face all these years. Why didn't I figure that out myself?" The psychiatrist said in a joking tone, "I guess that's what you pay me for." They both laughed.

COUNTERTRANSFERENCE

The phobic patient elicits three major countertransference problems: the benevolent omniscient, omnipotent parent; condescending infantilization; and frustrated anger. The patient seems to want to be treated as a helpless child. If the therapist goes along with this, he often adds the condescension that reflects his feelings about adults who want to be treated as infants. The presence of this response may reflect the therapist's difficulty with his own feelings of dependency, but it may also suggest that he is overresponding to the patient's demands.

If the therapist initially accedes to the patient's demands, accepting omnipotent idealization as reality rather than transference, he may eventually grow irritated and angry. If the clinician then reveals this
anger, the patient will feel that his transference fears have been confirmed and that treatment is another strange and frightening situation in which he is helpless when confronted with a powerful and arbitrary parent.

The anxiety disorder patient has more overt anxiety and often elicits responsive anxiety in the interviewer. This anxiety often leads to contradictory short- and long-range goals—the immediate soothing, calming effects of reassurance and support may be antitherapeutic in the long term. The problems of sensing the amount of anxiety that the patient can tolerate at any given stage and of timing interventions appropriately are a major challenge to the art of the therapist.

CONCLUSION

The anxiety disorder patient is responsive to a number of therapeutic approaches. This is true of all the anxiety disorders. Cognitive-behavioral therapy, psychodynamic psychotherapy, and the judicious use of medication all potentially have a part to play in the effective treatment of the anxious patient. An awareness of the patient’s individual psychodynamics should inform the application of these differing treatment modalities in order to enhance therapeutic response.