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Anxiety : Relation of Conceptualization to Therapy

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ABSTRACT

The concept of anxiety in psychiatric practice is getting to be more and more ambiguous. The connotative history of this vague term has come to indicate how little progress has been made in both descriptive psychiatry as well as in the structural orientation about the how of organization of the psyche in health and disease.

The impact of such a situation on the nosology and management of mental disorders labelled under such term or including such phenomenon (symptom) was discussed. The need for a new approach and perhaps a new language is proposed.

INTRODUCTION :

Every word* has its particular connotative history. A concept included in a symbol is the result of such history at a particular moment of evolution. Psychiatric vocabulary is the least stable. and in the view of many psychiatrists is of doubtful pragmatic value. The word boundaries in psychiatry (like ego boundaries in schizophrenia) are becoming more ill-defined, thus hyperpermeable inspite of all the effort given by the members of national and international nosological committees The concept of anxiety is in no way an exception.

The problem is not the least theoretical. It has its direct implications on the how of practice, particularly in terms of therapeutic technique and goal .. The term anxiety provides an additional source of ambiguity since it is originally a lay expression. As Davitz (1969) put it " ... the use of such every day words ..... adds a considerable

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*** I am not going to tackle how translation could alter the concept included in such verbal symbol and how this could affect clinical practice. If anxiety is believed to be a recent mistranslation of the German word " angst " while both languages have the same common Latin origin, what could be the case for Arabic translation by an Oriental thinker ?**

potential for confusion in a field that hardly needs additional sources of noise in the channels of professional communication ".

The available nosological disciplines, placing anxiety as a neurosis or the mother neurosis stress two main dimensions viz; a free floating ill defined fear as well as the autonomic concomitants. Neither could be traced to the Latin origin where "anxietas" means disquiet while " angor" means constriction. However neither the psychiatric connotations nor the original meaning has adequate correlation with the differential therapeutic orientation.

As a developing country, with our own handicap, we should not be satisfied by reproducing the imported, sometimes illusive, information about the subject. We have neither time nor personnel to loose searching for the right definition or going around in the statistical jungle. We have but to search before all for the useful meaning. As Kendell (1975) puts it " .... it is almost meaningless to ask which is right. The appropriate question is always which is more useful or appropriate and the answer will vary with the purpose in mind. " I hope or believe, that our purpose in mind is primarily therapy and not the least stereotyped pseudocom. unication.

CONCEPTS AND PRACTICE :

A concept in psychiatry is primarily derived from feedback in clinical practice. The dimensions I intend to clarify are but the direct result of my clinical experience and personal orientation. It should be understood as a logical - phenomenological approach through an evolutionary psychopathological orientation where psychopathology is neither the etiology nor the symptomatology but the psychostructural morbid organization. Both conceptualization and practice are directly influenced by the personal defenses of the psychiatrist as well as the attitudes and values imposed upon him from society considered as a spatio - temporal environment. instance :

1 — Anxiety for a therapist who conceptualizes health as the " anxiety - free nirvana " would differ from another believing in life as a crescendo dialectic synthetic formation continuously in the make.

2 — Understanding anxiety as a " language for " rather than a " manifestation of " or " resulting from " that is to say adding teleology

to determinism is apt to alter the therapist's stand and to favour certain therapeutic procedures.

3 — Interpreting the presenting " form of anxiety " in terms of behavioural manifestation of some morbid organization (personality organization as well as neuronal and molecular) varies from interpreting it in terms of some manifestations of this or that brain amine or in terms of a mal - learning or residual fixation.

THE SUGGESTED APPROACH :

It does not suffice for a psychiatrist to delineate normal motivating anxiety from the handicapping neurotic one. I am going to introduce the broadlines of two dimensions that I have judged through my practice to be basically relevant to therapy. Before that it is necessary to delineate the phenomenological - structural background of anxiety being responsible in one way or another for the behavioural outcome. As such anxiety should be considered as **a phenomenon of hyperarousal resulting from a disproportion between the scope of awareness and the intrapsychic activity.** Behaviourally, it can present as independent syndrome presenting mainly with that ill - defined fear and associated autonomic manifestations or it may be associated with other symptoms as part of some other syndrome.

I — The Awareness Dimension :

The disproportionate hyperarousal referred to in the structural notification could result from an increased dose of awareness or otherwise a decreased one in relation to both the intrapsychic activity (& content) and the external objective facts. Such disproportion could be normally or abnormally experienced. Thus one can conceptualize anxiety over this scale in terms of :

1 — Hyperawareness anxiety :

In principle, the adult march of growth includes such an overdose of awareness as an essential start. On the other hand early psychotic experience (usually before differentiation or massive alienation) manifests by a similar experience. To mention some variants one has to go through a scale including normal, healthy, creative as well as various morbid states of hyperawareness. To mention some we have :

a — Existential anxiety :

This is a recently applied term in psychiatry referring to a certain degree of awareness of one's true self (e.g. in boundary experience of K. Jaspers) or of the absurdity and meaninglessness of the world as such (J.P. Sartre). This type should not be considered as either healthy or unhealthy in itself. Under appropriate conditions it should be an intermediate stage (see next type).

b — Cross - Road anxiety :

This term has been used by the author (Rakhawy 1979) to refer to the cross road crises declaring the peak of a growth experience where the old organization fails while the new one has not been sufficiently established or put into action. When anxiety predominates such crises the suggested term is justified. It is characterized by deeper reorientation in one's self and the reality around and by definition, could take any road according to different variables.

c — Nihilistic anxiety :

This type is to be considered as a variant of existential anxiety but with selective hyperawareness related to the futility of life (e.g. Camus) The overdose of awareness uncovers the aimless, doubted finality of one's existence. Depression or nihilistic schizoid withdrawal may be met with from the start or may ultimately supervene. Here the selective hyperawareness is usually related to the limited existence span of one individual and not infrequently projected onto others.

d — Cosmic (& Mystic) anxiety :

When hyperawareness extends beyond one's own existence (as a mesocosmos) to surpass his limited personal time and space, one may be confronted with cosmic orientation (macrocosmos) beyond his ability to assimilate such experience at once. This may continue in either way, either to establish a higher level of relatedness and harmony beyond one's own existence and thus elaborates an anormal experience (not necessarily abnormal). or, otherwise, it may start some other morbid march towards manic detachement or still worse disorganizing outcome.

e — Alarm (internal phobic) anxiety :

This type is usually described under phobic disorders in terms of fear from insanity, loss of control or any other fear from intrapsychic structure or activity (e.g. from being helpless once again - of impulsive homicide of incestuous inclinations and the like). It is not fair to put such fears as simple phobias since they declare directly the result of hyperawareness in what is actually present inside everybody. Such awareness could be related to uncovering (or impending uncovering) of deeper intrapsychic structure , usually reactivated , of ontogenic or phylogenic origin perceived as they are. The so called psychotic ego is perceived as an active potentiality rather than a negative outcome of some breakdown of the previously existing organization. It is claimed that such phobias are usually concomitant with depression. This seems partly true but its structural interpretation still refers to hyperawareness in one's intrapsychic content and the depression is the result of excessive control in a trial to compensate for such dangerous awareness.

f — Psychotic awareness anxicty :

In the early stages of a psychotic process, the patient is occasionally submitted to sudden uncovering of the intrapsychic content which is perceived as such by the patient rather than feared of , acted out or alienated. This phenomenon has been described by the author as psychotic awareness (Rakhawy, 1979) in contrast with the psychotic insight of Arieti (1974). This direct perception of the self and reality as ' they are ' is usually associated with real apprehension, astonishment, fluctuant perplexity, depersonalization experience and occasional suspicion. Such experiences are usually mixed declaring both hyperarousal and hyperawareness, the outcome of such stage may be altered according to different circumstances including the type of therapy applied then.

g — Creative anxiety :

Such type characterizes the prodroma (or preparatory stage) of creative experience. Basically it could not be differentiated from existential or cross - road anxiety. It also has certain features in common with both cosmic anxiety and the psychotic awareness types.

Hence, it is the creative outcome that determines its categorization here as if it is a diagnosis in retrograde.

2 — Hypoawareness Anxiety :

The anxiety in this variant manifests predominantly as motor and autonomic hyperarousal. The disproportion between a restricted awareness in the face of an unduely activated intrapsychic structure is the responsible factor behind this type. I am not going to give corresponding examples to illustrate this type since they constitute the main bulk of the anxiety syndromes as described behaviourally. However, tension anxiety, exhaustion anxiety (neurasthenia), agitation anxiety and projected phobic anxiety could be included here. All such types usually overlap in different degrees.

Coming back to the relation of conceptualization to therapy we can remember that the goal of therapy is to restore, once again a functioning balance between the dose of awareness and the ability to assimilate its consequences as well as to control the surplus intrapsychic activity. This could be established through various procedures appropriate to the individual case. It includes inhibiting older intrapsychic structural organizations by some specific drugs on one side or assimilating the awared of objective potentialities of one's existence through various psychotherapeutic procedures. Other detailed manipulations are beyond the scope of this paper.

II — The Psychostructural - Organization Dimension :

The second principle dimension which participates in our conceptualization of anxiety as related to therapy is the how of organization of the personality structure where the outcome is simply the outer facade of such organization. This dimension is the most difficult to assess but again it is perhaps indispensible to uncover. It is directly related to the psychiatrist's theoretical orientation about the how of organization of the personality and the brain. I am going to introduce the different presentations of anxiety through a multiorganizational hierarchical approach. In my thinking it could be traced back to Hughling Jackson, developed by Henry Ey and simplified in transactional terms by Eric Berne.

In terms of the inter-relation between intrapsychic structural organizations (assumed or real persons) certain examples may be provided :

1 — Confrontation Anxiety :

When two main organizations (say : old - new, child - parent, social-native or right - left hemispheres etc) confront each other for dominance while both are equally strong some behavioural manifestations are presented declaring this equivalence. Depression is the main result but occasionally a special form of anxiety dominates the clinical picture and occasionally substitutes depressive symptoms altogether.

2 — Oscillatory Anxiety :

Instead of confronting each other; simultaneously reactivated structural organizations may oscillate rapidly with one another presenting symptomatically as hesitancy, unsustained activity, occasionally lability and ambivalence. Such type is mainly met with in early disorganizing psychoses.

3 — Conflict Anxiety :

The word conflict is usually used in psychiatry to declare the dynamic relation of any opposing forces. In this context it is indicative that one structural organization has achieved some relative dominance over the other which latter does not yield totally, still performing its active traction and influence, although at a distance. This assumed distance differentiates this type from confrontation one. Behaviorally tension and exhaustion dominate the picture.

4 — Disorganization Anxiety :

One can identify here the dispersion of energy as a result of multiple organizations losing their own unity. Perhaps this is mainly manifested in schizophrenic anxiety and in the course of organic dementia (crises de perplexité of H. Ey). It is characterized by vagueness hesitancy, fluctuation, and hyperkinetic agitation. It could be also met with in some akasthesias resulting from prolonged use of major tranquilizers. Such complication could be interpreted in terms of irregular displacement of energy through loosely associated fragments of organizations.

Such approach for identifying and understanding anxiety from an organizational point of view is evidently directly related to therapeutic planning. The how of reorganization of such disharmonious relation or dispersed fragments (through physical, chemical, or psychological means) is but psychiatric therapy.

CONCLUSION :

As Tyrer (1979) put it " ... The recognition of anxiety in a psychiatric patient is but the first step in classification. It is more logic that the same principle applies to therapeutic planning. Answering the following questions may help to clarify one's concept about a particular case and consequently the nature of possible therapy to be applied :

1 — Is anxiety in a given person, a declaration of an overdose of awareness or a defense against an impending untimely dose ?

2 — What is the underlying morbid (not only premorbid) structural organization ?

3 — How is it presenting ? predominantly behavioural or as a phenomenon related to consciousness and subjective experience ?

4 — What does it mean in this particular person in this particular time of his evolution in that particular society ?

5 — What are the resources of such a person to cope with such morbid situation ? Will he be able to assimilate more of the activated structure or is he obliged to suppress whatever is intolerable (the same applies to the therapist depending on who is he and what he is after).

REFERENCES

Arieti, S. (1974) *Interpretation of Schizophrenia*. New York: Basic Books.

Davitz, J. R. (1969) *The Language of Emotion*. New York : Academic Press.

EY, H. (1950) *Etudes Psychiatriques* : *Aspects Semiologiques*. Tome II, Paris : Desclee de Brouwer et Cie.

Kendell, R. E. (1975) *The Role of Diagnosis in Psychiatry*, Oxford Blackwell Scientific Publications.

Rakhawy, Y. T. (1979) *A Study in Psychopathology*. Cairo : Dar El-Ghad.

Tyrer, P. (1979) Anxiety states. In Granville-Grossman, K. (ed.) *Recent Advances in Clinical Psychiatry*. 3 *rd* ed. London : Churchill and Livingstone.

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الموجـــــز

القلق : علاقة تكوين المفـــاهيم بالعـــلاج

ان مفهوم القلق فى الممارسة الطبنفسية قد أصبح ملتبسا بشـــكل متزايد . ان التاريخ الدلالى لهذا المصطلح الغامض قد بين التقدم القليـــل جدا الذى تم فى كل من طب النفس الوصفى ، وكذلك الاتجاه البنيـــوى الخاص بمسألة « كيف » يكون تنظيم النفس فى الصحة والمرض .

وقـــد نوقش فى هـــذا البحث تأثير مثل هـــذا الموقف على تصنيف الاضطرابات الطبنفسية المندرجة تحت هذا المصطلح أو المحتوية على تلك الظاهرة (العرض) .

وقد طرحت الحاجة الى طريقة جديدة لمحـــاولة الاقتراب والفهم ، وربما (أيضا) الحاجة الى لغة جديدة .

ABSTRAIT

L'anxiété : la Relation de la Conceptualisation avec la Therapie.

Le concept de l'anxiété dans la pratique psychiatrique devient de plus en plus ambigu. L'histoire de la connotation de ce terme imprécis est arrivé à indiquer combien il y a peu de progrés qui a été fait dans la psychiatrie descriptive aussi bien dans l'orientation structurale concernant le comment de l'organisation du psychisme dans la santé et la maladie. L'impact de cette situation sur la classification et le traitement des troubles mentaux nommés par ce terme ou comprenant ce phénoméne (symptome) a été discutés. Le besoin pour un nouvel approche et peut être pour un nouveau language est proposé.

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