

ANXIETY AND ITS IMPORTANCE IN
PSYCHIATRY

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Reprinted from
THE BRITISH JOURNAL OF PSYCHIATRY
SPECIAL PUBLICATION No. 3

CHAPTER 28

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Many of you will remember the musical piece "The Age of Anxiety" or have read the book by Auden of the same title. Today the word anxiety is part of everyone's vocabulary. The topic is so significant to contemporary man, and psychiatrists are so concerned with man's most peculiarly human problems, that it is little wonder that this symposium has been dedicated to the exploration of anxiety.

Why do both psychiatrists and non-psychiatrists speak so much about anxiety? Is it that man today feels more condemned to anxiety than he did in other epochs? Is it that we live in a world which is especially anxiogenic or anxiety-provoking? If anxiety is so bound to human conditions, it is logical to suppose that, be it normal or pathological, it has always existed; if, on the other hand, it is found to be grounded in historical crisis, it is also logical to think that in other previous crises there also existed this efflorescence of anxiety. It scarcely seems necessary to say that I use the word "crisis" in its literal sense, referring simply to a phase or moment of accelerated change, when new values, new ideas and new projects in the life of man take shape and which presupposes, therefore, a becoming aware of the inadequacies of the preceding ones.

History teaches us that the human reaction to the threat of anxiety varies according to historical time, and that in the sphere of feelings there exist substitutes and interactions which language is scarcely able to express. The interrelation of tedium, nausea and fatigue is well known; but in one form or another, anxiety is part of not only the condition but of the very human essence, as indeed Jeremiah lamented: "My anguish, my anguish! I am pained at my very head, my head is disgusted in me."

In spite of this long history something peculiar characterizes the anxiety of con-

temporary man. Tillich wrote that "at the end of ancient civilization *ontic anxiety* is predominant, at the end of the Middle Ages, *moral anxiety*, and at the end of the modern period, *spiritual anxiety*"; what Tillich calls "spiritual anxiety" is the anxiety "of emptiness and meaningless. . . . We are under the threat of spiritual non-being."

We are, nevertheless, psychiatrists and, as such, doctors of medicine. Our field of study and action is pathology, in this case, pathological anxiety. What is pathological anxiety? The schema customarily used postulates that, although anxiety belongs to the dynamics of everyday life, there are especially conflicting situations where anxiety breaks out like an eruption. In other words pathological anxiety is differentiated "prima facie" from normal anxiety because of its intensity. If one troubles, the other disturbs. In psychiatry, this schema is confirmed by the observation of transitional forms between neurotic and psychotic anxiety, precisely because the latter is more intense than neurotic anxiety. The importance of "quantity" in the experience of anxiety is evident; from thence come attempts to measure it psychologically as well as physiologically, as we have heard in the contributions of Hamilton, Eysenck, Pichot, Lader and Aitken. But there is an important factor concerning this quantity to which I should like to call attention. The quantity reaches a pathological degree when it surpasses the inherent ability of the subject to bear it. Authors as different as Freud and Tillich have made use of this concept in determining the boundaries that separate normal from pathological anxiety. A torrent of stimuli overcomes our ability to receive and embody them, and produces anxiety. The absence of stimuli, as in the experience of sensory isolation, also causes us anxiety. The accumulation of

stimuli is anxiety-provoking, as in a life too full of conflicts, whilst in contrast we may agree with Pascal when he wrote "The silence of infinite space frightens me." The key lies in the relationship between the person and his world; as to the explanation of pathological anxiety perhaps what is most important is what happens within the subject himself.

To most clearly express my beliefs regarding the differences between normal and pathological anxiety, I must refer to the problem of the depressions. Depressions may be reactive or endogenous (apart from the intermediate forms to which our attention is increasingly directed). The reactive depressions are determined by a traumatizing situation in the affective life of the subject, who thereby falls into a state of profound sadness. In endogenous depressions the sadness does not come from without, it is not psychodynamic, but comes from an alteration—as yet unknown—in the regulation of the nervous system, and is deduced from the appearance of a sadness without motivation. Our forebears were well aware of this fact. Alfonso de Santa Cruz, in his book on melancholia—predecessor to Burton's famous work—spoke of the melancholia that appeared without a provoking motive, "sine metus", which translated into contemporary language, means "endogenous melancholia".

The presence or absence of a motivating factor is not, in many cases, sufficiently clear to allow the differentiation of one form of melancholia or depression from another, owing to the existence of a projecting or attributing mechanism. The patient needs to find an explanation of what is happening to him. For these reasons the differences between reactive and endogenous depression must be established by means of a clinical analysis, since the course and the therapeutics are different. This symptom analysis is carried out in the same way that the physician makes a differential diagnosis. The psychopathological analysis shows that the sadness from endogenous depression brings forth characteristics different from those of reactive or motivated sadness, which related the appearance of this sadness to an event that preceded it. The ultimate course of the melancholic phase and its treatment demonstrates that such an attribution or projection was no more than a

defence mechanism. It is a sadness that is found so deeply rooted in the body that it can well be classed as vital sadness, somatized or embodied. It is a sadness that, more than a feeling, appears like a "hybrid" made up of feeling and sensation. (Lipps' "Gefühls empfindung"; Scheler and Schneider's "Bodily and vital feelings or emotions").

The same occurs with the anxiety of the neurotic. It is an anxiety so bound to corporeality that we may speak of an embodied vital anxiety. It too is a hybrid state made up of sensation and feeling. This somatization of anxiety suggests that it is due to the pathological intensity of the mood state. Feelings are expressed through certain anatomical systems amongst which vegetative correlations are pre-eminent; but in this case it is not, as I see it, a question of a somatic projection of feeling or emotion, but that the latter is primarily physiodynamic in its genesis and not psychodynamic. The James-Lange theory put forward the view that the vegetative system was primarily affected, and that emotion was the name we give to this vegetative alteration. The famous phrase, "I do not cry because I am sad, but I am sad because I cry," expressing so clearly the James-Lange theory, was demolished by Sherrington, and is today of only historical interest. But vital sadness and vital anxiety demonstrate that it is the body which is sad or anxious, while this sadness or anxiety is not produced by the peripheral vegetative regulation but depends on central mechanisms. Roubicek, Levi and Lader have given us much food for thought concerning this aspect of anxiety. The clinico-psychological analysis of the symptoms compels us to accept the existence of vital or endothymic sadness (Scheler, Schneider, Lersch) in depression and a vital or endothymic anxiety in neurosis (J. J. López Ibor).

Kubie envisaged the peculiarity in the neurotic structure as a repetition: "Whether an act is healthy or neurotic depends only on the constellation of forces which determine it. If these forces, be they purely psychological or a combination of psychological and organic, are of such a nature that they pre-determine the automatic repetition of the act independent of any other consideration, this act is neurotic, and

the forces which determine it are generators of neuroses." This is the essence of what is psychopathological in human conduct. Kubie, who did not want to be included among those favouring the organophobic or psychophobic theories, admits that such repetition can be organically and psychologically determined.

In fact, we are confronted with one of the most important problems of the psychopathologically abnormal life. In a specific moment in the evolution of his thinking, Freud untangled the relation between the impulse to repetition ("Wiederholungszwang") and the death instinct ("Todestrieb"). There is something in the organic make-up which drives it relentlessly forward, from life inexorably towards death. This inexorable tendency towards repetition appears in the constitution of neuroses and of all psychosomatic disturbances. Reiteration is also included in the dynamics of many psychotic disturbances. When a crisis of anxiety passes, it leaves in its wake a series of phobias or obsessions, subject to the necessity of repetition. In my book "Vital Anxiety" I was inclined to admit a dual genesis of both phenomena. Repetition—I thought—was anchored to biology and was related to the tendency to regress which exists in all manifestations of primeval life.

But the innermost part of the phenomenon is much more complex. In reality, the anxiety-provoking experience is a limited experience which cannot be undergone in its entirety. In proportion as it nears its zenith it becomes more insupportable. In their own internal dynamics, the regulatory impulses prevent the experience from reaching its limit. This is why the patient, near to succumbing to the insupportable quantity of anxiety which inundates his being with nothingness, adheres to something, to a psychic content. The anxiety then ceases growing and can become crystallized around a content which is presented as its "motive". Thus are constituted the phobias. The role of the defences is obvious in the dynamics of this process: in place of totally invading the personality, anxiety becomes linked with a concrete object. The appearance of phobias presupposes a mitigation of the anxiety. Repetition is a way of giving temporal limits to the infiniteness of the anxiety.

This disturbance of the anxiety-provoking temporality appears in the life of primitive man, as is shown in their use of cyclical instead of historical time. Cosmic anxiety in primitive man is tamed through the repetition which characterizes cyclical time. "What will happen?" "What will come later?" Historical progress is anxiety-provoking. The new is a category which makes the primitive shudder. The new must be integrated in order to lose its anxiety-provoking quality, in order to be known. The negation of history, mechanical repetition of the cosmic cycles, or of the social or individual life, defend him against the "terror of history". The "new" is startling in life because it shows the possibility of something further on. From this horror man saves himself by thinking about what happened "as in the other times".

It is a considerable advance for man to be able to accept historical time, the future; and this acceptance cannot be made without a certain amount of anxiety. As the speed of historical time has increased, so has the quantity of anxiety increased. Contemporary man is stricken by this experience. The phobic, in reference to his phobia, lives in cyclical time instead of historical time. The eternal return of the phobia is a defence against the anxiety-provoking experience which cannot be eliminated, but only minimized. It is a vaccination against anxiety by diluting in time the presence of his phobia.

Repetition presides over other pathological phenomena. The pathology of the extrapyramidal system, for example, is governed by the principle of repetition. Munk spoke of these cases, an example being the role of the corpus Luysii in hemiballismus, saying that an extrapyramidal centre or nucleus entered into a period of hyper-excitability when it was isolated. Other neurologists have agreed (Lotmar, Bing) and it has also been observed in many psychosomatic disturbances. The illness appears in an initial crisis, for example, a precordial crisis of anxiety, and then continues to be manifested in extrasystoles, which become enveloped in an atmosphere of anxiety. In one of my cases, a woman saw her husband condemned to death by a tribunal, and turned her head away with a gesture of horror. In the first phase of her illness there was a psychogenic torticollis. Two

years later the diagnosis was clearly that of a torsion spasm.

It is true that in neurosis there exists a psychodynamic structure, but its essential nucleus consists of the basic anxiety which I have described. I would venture to affirm that the future evolution of the doctrine of the neurosis will follow an inverse path to the one it took in the hands of Freud. In his early writings Freud described actual neurosis, and transference neurosis or psychoneurosis. In actual neurosis he assumed in some way a physiodynamic genesis, and in transference or psychodynamic neurosis only psychodynamic mechanisms. Subsequently, he suppressed the first mechanism, and psychodynamics became predominant.

The recognition of this basic anxiety of a psychodynamic or physiogenic character helps us to understand many of the current problems of anxiety. I shall mention only one to illustrate the importance of this problem. Nowadays the efficacy of deep psychotherapy in the treatment of neurosis is widely discussed. Between those that affirm that without psychotherapy there is no possible cure and those that say that deep psychotherapy does not influence the cure of neurosis, there is a whole area of different opinions. As I see it, the key to the matter is to be found in the following: The majority of the neuroses follow a phasic course with a tendency to remission in almost 70 per cent. of cases. If anxiety is the nucleus of a neurosis, as has been asserted by Freud, and basic anxiety is of an endothymic character, such as the sadness of the melancholic, it is no wonder that there also exists in a neurosis a tendency to follow a phasic course, as may be seen in melancholia. This analogy should not prevent us from recognizing the differences, for instance that there exist longer phases in the neurosis, and that there are psychodynamic factors which determine the psychotherapeutic accessibility of these psychodynamic structures; conversely, that the true endogenous depressions are even more impregnable to psychotherapy than are the schizophrenias and also the true basic constitutional anxiety types.

The above-mentioned character of basic anxiety explains to us, as I see it, another

fundamental fact—the action of certain drugs on the neurotic state. It has always been known that drugs which influence the vegetative nervous system, that is, the vegetative regulation of the emotions, act as sedatives, allaying anxiety; but what is really new is the idea that there exists a primary psychopharmacological action on morbid anxiety, and therefore on the neurosis, such as may be seen in the depressions. Long experience has shown that the application of a pharmacotherapy similar to that used in depressions, produces excellent results in the neurosis. Cazzullo has spoken to us about these results in his excellent paper on psychopharmacology.

Some years ago I decided to employ vegetative shock as a therapy using, usually, acetylcholine. The new psychotropic drugs have provided us with new weapons, about which I will not digress now. My latest therapeutic tests, excellent in their action, have shown the efficacy on the non-psychotic anxiety syndrome of M.A.O. inhibitors and some derivatives of imipramine (e.g. monochlorimipramine). By intravenous administration in the form of a pharmacological shock I have been able to confirm a decisive improvement in their efficacy.

We psychiatrists are particularly concerned with abnormal anxiety. We have at our disposal psychotherapeutic and psychopharmacological treatments. Yet above all, a better understanding of our patients is essential in leading us to a better understanding of man and his devils, since the devils in modern man are personified in the form of those assaults carried out by an ineffable anxiety which invades him and makes his ego experience his weakness and impotence against such inner devils.

To be able to bear or obviate being dominated by normal anxiety, as Tillich said, "courage to be" is necessary. The spread of anxiety states in man today may be the result of man's complex nature, the over-production of stimuli, and the lack of that "courage to be". The social implications of the problem are self-evident. Anxiety is a topic which will pre-occupy the minds of psychiatrists all over the world, and where more fittingly should this problem be discussed, than in the symposia of the World Psychiatric Association.



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