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INTRODUCTION

Subjective feelings are commonly considered as belonging to the core of emotion. When asked to define a particular emotion, people in most cases refer to mental states like feelings, sensations, sentiments, or inclinations. However, as soon as these subjective feeling states are subjected to scientific scrutiny, they seem to resist further examination. What appears to be crucial for the patient, i.e., the subjective experience of emotion, seems to withdraw and even to dissolve as soon as one tries to adjust it to the frame of scientific method and experimental design.

The study of emotion has to a large extent been concerned with physiology, motor behavior, verbal expression, and cognition (1). These phenomena are, indeed, strongly associated with affective experience, but they do not have affective quality in themselves. Bodily symptoms and cognitions may contribute to the disturbing and compelling character of feelings and emotions, but they are not as such disturbing and compelling.

This chapter on the subjective dimension of anxiety is written against the background of this gap between the ordinary and the scientific understanding of emotion. Anxiety is a major example of this gap. In the scientific literature relatively little has been written about anxiety as a feeling state (see Refs. 2,3). Even less attention has been paid to the varieties of the experience of anxiety.
Panic, fright, terror, dread, fear, worry, and apprehension—these terms give only a weak impression of the immense diversity of the subjective experience of anxiety. Clinicians, of course, are familiar with this diversity. Their job is to unravel the meaning of the many images, metaphors, and nonverbal expressions patients use in order to reveal what is going on in their minds. From a scientific point of view these communications may be called idiosyncratic. But, when listened to carefully in a clinical context, these idiosyncrasies often appear to be meaningful, for instance, when seen from a biographical perspective. The history of anxiety disorder is a learning history, with often highly specific triggers and sustaining factors.

The study of the subjective dimension of anxiety is not only haunted by the enormous diversity in the experience of anxiety. Another factor that contributes to the gap between the ordinary and the scientific understanding of anxiety seems to be related to something in the feeling of anxiety itself, i.e., its nontransparency. Freud alluded to this in one of his early writings (4), where he noted that in anxiety neurosis the affect of anxiety "proves to be non-reducible in the psychological analysis." According to Freud, the fears of anxiety neurosis differ from phobic anxieties in that they cannot be explained by the mechanism of substitution. Phobic anxiety becomes transparent by referring to repressed memories and representations. In the Freudian view, the phobic situation serves as a substitute for the object or situation that was initially feared. In anxiety neurosis, however, the feeling of anxiety cannot be analyzed in this way: it is unanalyzable in a psychological sense. Freud explains this by referring to biology: the anxiety of anxiety neurosis is the mental analogon of a somatic quantity of (libidinal) energy, which is processed inadequately and conducted to the wrong neural paths. This biological view indeed shows some resemblance to some recent opinions about panic disorder.

In this chapter I will take the almost impenetrable and nonreducible feeling of anxiety as a paradigm case. This case will serve as a guide in our examination of the subjective dimension of anxiety. First, I will give a brief summary of the three main directions in the interpretation of anxiety. Then, I will comment on a brief excerpt of a conversation with a patient with panic disorder with agoraphobia. After this I will discuss some of the distinctions which are drawn in descriptive psychopathology, anxiety in the context of psychosis, and the research on the so-called ideational or cognitive component of fear and anxiety.

**MAIN DIRECTIONS IN THE INTERPRETATION OF ANXIETY**

From a historical point of view, three lines in the interpretation of pathological anxiety may be discerned. First and foremost, there is medical tradition,
which since antiquity has dominated the theoretical literature on anxiety and which, at least during the last 150 years, has tended to favor a biological approach. According to this tradition anxiety is rooted in a dysbalance in a physiological and/or neuroendocrine equilibrium. Subjective feelings are the epiphenomena of this dysbalance. From a medical viewpoint, their relevance is limited. At best these feelings may provide a clue for the identification of a particular, dysfunctioning biological subsystem.

Second, the concept of anxiety as an inner threat must be distinguished. Well known as it is now, one can hardly imagine the revolutionary significance of this concept as it emerged in the late nineteenth- and early twentieth-century psychoanalytic literature. Contemporary defenders of this view can be found in psychotherapeutic circles and in some branches of cognitive psychology. They do not deny that fear and anxiety may be related to some external danger. In addition, however, they maintain that in human anxiety it is often inner threat that is of central importance. The patient is disturbed by the inner danger of being out of control and vulnerable, physically or socially.

Finally, the existential concept of anxiety is worth mentioning, a concept dating from the seventeenth and nineteenth centuries (Pascal and Kierkegaard, respectively), which via existential phenomenology inspires the work of existential psychotherapists and anthropological psychiatrists in our age. According to this concept the feeling of anxiety must be seen as the mental expression of a frustrated urge for self-realization or as the expression of the imminent annihilation of personal identity and psychic integrity.

These three traditions still seem to diverge. Contemporary psychiatry gives the appearance that medical tradition is enlarging its domain at the expense of the psychoanalytic and anthropological traditions. It should be noted, however, that psychiatry as a medical discipline has incorporated elements of the second tradition, for instance, the idea of anxiety as a signal of inner threat and some of the contributions of cognitive psychology. This chapter attempts to show that integration of some of the viewpoints of the anthropological tradition may be of some relevance.

THE FEELING OF ANXIETY

Let us proceed with a fragment of an audiotaped interview (I) with a 35-year-old, solitary-living, male patient (P) who had suffered from panic disorder with agoraphobia for more than 15 years.

P: It is a kind of empty feeling. An emptiness... here (points with his finger to his stomach)... an empty space in which something is scraping. Yet there is nothing in there.
I: Is it a feeling in your stomach?
P: Yes... yes... it is here (points again and smiles).
I: You smile?
P: Yes, it is so weird. That such a thing embitters one’s life! But it makes me so sick... it is so strong... I cannot resist it.
I: What makes it so unpleasant to have that feeling?
P: “It is as if something is going to happen... something very serious and threatening, I don’t know what. It disturbs me. It is such a strong feeling, I can’t ignore it... I must give in. If I don’t, it becomes even worse. It dominates me. My mind loses control.

There are several remarkable points in what the patient says. Perhaps most remarkable, however, is what the patient does not say, i.e., that he suffers from massive fear and that he is frightened by his bodily sensations. The patient clearly suffers from an anxiety disorder. But terms like fear, panic, terror, or anxiety are not even mentioned. The patient seems to omit what is most obvious. What is this?

From a practical point of view, one might recall the well-established fact that patients with panic disorder tend to attribute their distress to physical disease. These patients populate the consulting rooms of general practitioners, cardiologists, gastroenterologists, endocrinologist, and gynecologists. They feel their anxiety but do not mention it, or consider it as secondary to some physical abnormality (5).

But again, why is this? Why do patients with anxiety disorders talk exhaustively about all kinds of physical complaints when it is anxiety that is the ultimate source of their suffering? The interview suggests that shame might be part of the answer. The patient smiles; he seems embarrassed by the futility of his complaints. He realizes that whatever he might say, it will always sound implausible and bizarre: “That such a thing embitters one’s life!” No matter how eloquent he might be, his verbalizations will never be adequate in revealing what is going on, that he has no choice, and that his abdominal sensations do not give him the opportunity to regain his calm. And that, indeed, may be shameful to admit.

But shame is only part of the answer. The interview illustrates this. Soon after the shameful moment of self-observation, the patient vehemently maintains that he cannot resist his abdominal sensations. It is a very strong feeling; it makes him feel sick. The vehemence of these assertions might be interpreted as an attempt to master the shame. But is also suggests that there may be another reason for the absence of words like anxiety and fear. The patient seems to be caught in a paradoxical situation, i.e., a situation in which, on the one hand, there is no reality other than these paralyzing sensations, and, on the other hand, little more seems to be left than to admit that these sensations are pointless. There is simply nothing to be explicit about or to be untangled. There are just these devastating sensations—sensations without an object and without a
cause, sensations that can hardly be communicated and that lock the patient in his Cartesian private world.

Sometimes, this discussion is short-circuited by saying that fear and anxiety, as emotions, are to be separated from bodily sensations. According to a popular (Jamesian) view, emotions like fear and anxiety should be seen as caused by bodily sensations. Others hold the opposite (Cannonian) view. They consider bodily sensations as the peripheral consequences of an underlying central state of anxiety (7). Whatever the evidence for either of those views, both are built on common ground, i.e., a conceptual and/or experiential distinction between bodily sensation and emotion. This distinction, however, should not blind us to the fact that bodily sensations may have emotional quality themselves. The patient in the interview is not only frightened because of his bodily sensations: his anxiety also consists of the specific, vital quality of these sensations. Interpretations which are based on a strong distinction between sensation and emotion tend to overlook that the experience of bodily sensation itself often involves more than simply a “cold” perception that something is happening in the body. The interview suggests that, in case of anxiety disorder, there is no such “cold” perception or distant self-observation.

What appears to be of central importance in the patient’s experience of his bodily sensation is the ineffectiveness of his attempt to regain control, the central feeling of weakness and powerlessness, and, ultimately, the feeling of unconnectedness and the ensuing awareness of being totally isolated. All of these elements seem to be implied in—and not secondary to—the experience of bodily sensation.

If this is true, the reason for the absence of terms like anxiety and fear can be construed in another way. It could be maintained that

1. The feeling of anxiety, in this case, precisely consists of this ineffectiveness, powerlessness, and sense of isolation.
2. The patient’s difficulty in verbalizing what is going on should be taken as one of the expressions of this core feeling of powerlessness and lack of control.
3. Terms like fear and anxiety, when used in an ordinary sense, do not entail these connotations, and, for that reason, often do not occur in the vocabulary of the patient.

Of course, these statements are somewhat one-sided. Speech samples show that in fact many anxiety disorder patients do use terms like fear, anxiety, and panic. In many cases there is clearly something they are afraid of: losing control of their thoughts or actions, having a heart attack, suffocation, rejection and/or abandonment, future disaster, and—also—bodily sensations. But this should not lead us to deny that there is an experience of anxiety that is still more elemen-
tary than these fears. The reason why this experience is often not verbalized in terms of anxiety could be that in ordinary language fear and anxiety are usually associated with a danger that can be identified. In cases of pathological anxiety, however, there is often no identifiable fear-provoking object, unlike the experience of anxiety itself or one of its consequences (losing control, suffocation, and so forth). This is why expressions like “fear of fear” and “fear of anxiety” have been introduced into clinical and scientific language. The experience of anxiety is often a double-layered one: behind the fear of a more or less concrete danger one can find a vital, sensation-like experience, which is much more difficult to put into words because it seems to lack a definable object. It is often this anxiety that is the object of the patient’s fears. Compare, for instance, the account of an anonymous surgeon (2):

It is as difficult to describe to others what an acute anxiety state feels like as to convey to the inexperienced the feeling of falling in love. Perhaps the most characteristic impression is the constant state of causeless and apparently meaningless alarm. You feel as if you were on the battlefield or had stumbled against a wild animal in the dark, and all the time you are conversing with your fellows in normal peaceful surroundings and performing duties you have done for years. With this your head feels vague and immense and stuffed with cottonwool; it is difficult, and trying, to concentrate; and, most frightening of all, the quality of your sensory appreciation of the universe undergoes an essential change.

What has been said here so eloquently in many cases will remain implicit in the experience of anxiety itself. Anxiety is not primarily the consciousness of being out of control and unconnected. It is, rather, the way in which the powerlessness and unconnectedness are embodied and lived.

To anticipate what will be said below, anxiety is first of all a vital and elementary experience. Its definition should not be reduced to the enumeration of its cognitive contents. Expectations, evaluations, images, and representations may be part of the experience of anxiety. But anxiety cannot be equated with these products of consciousness, for many people have these anxiety-provoking expectations, evaluations, images, and representations without becoming anxious.

DESCRIPTIVE PSYCHOPATHOLOGY:
OBJECT-BOUND FEAR AND OBJECTLESS ANXIETY

To be sure, what has been said until now comes very close to an old and well-known distinction in descriptive psychopathology, i.e., the one between object-bound fear and objectless anxiety. It is interesting to see how this distinction has been dealt with in the various traditions in the interpretation of anxiety.

Neurobiologically minded investigators tend to a view in which objectless anxiety is seen as the subjective correlate of an archaic and purely organic state,
whereas object-bound fear is regarded as a product of the activity of brain areas mediating higher cognitive processes. Gorman et al. (8), for instance, suggest that the distinctions in the experience of anxiety correlate with different degrees of cognitive complexity. Cognitive complexity in its turn is related to neuroanatomical location. Referring to MacLean's concept of a tripartite organization of the brain, they hypothesize that panic is mediated by the brain stem, free-floating anxiety by limbic activity, and anticipatory anxiety by frontal processes.

Psychoanalytic investigators tend to a similar threefold distinction, by discerning between traumatic or "automatic" anxiety, corresponding to a state of biological helplessness at birth, free-floating or signal anxiety, which serves as a warning signal of this traumatic anxiety, and anticipatory anxiety, which is associated with a particular object representing a real or imaginary threat. Interestingly, however, this division is not interpreted as merely a reflection of differences in cognitive complexity, but as a challenge to uncover what is nontransparent and objectless at first sight. It is true that Freud never completely abandoned the idea of a purely organically based form of anxiety (as the basis of actual or anxiety neurosis). But in later versions of his theory of neurosis, Freud developed the notion of anxiety as a warning signal. Objectless, or free-floating, anxiety is then viewed as a signal, which is produced by the ego and which serves as a warning of an unconscious conflict. The cognitive impenetrable nature of this anxiety, rather than being a reflection of a more primitive neuronal state, serves as an incentive to lay bare those unconscious inner conflicts which are supposed to generate this anxiety.

Behaviorally oriented scientists traditionally have not been as interested in the phenomenal qualities of the experience of anxiety as they were in its antecedents and behavioral consequences. It is only since the advent of cognitive science that this picture has altered. We will discuss some of the results of the new research later.

Finally, mention should be made of the continental, anthropological tradition. Building on the work of the philosopher Sören Kierkegaard (9), psychopathologists like Jaspers (10), Kronfeld (11), Goldstein (12), and Störring (13) held the view that behind all kinds of fear associated with concrete objects like height, blood, crowds, small rooms, etc., there is a more fundamental anxiety, which lacks such a definable object and does not even need to be conscious. Goldstein, for instance, exposed World War I victims with organic brain damage to complex cognitive tasks. He observed that his patients displayed overly controlling and catastrophic reactions. In spite of their massive physiological and psychomotor symptoms, the patients were often unaware of their anxiety. Because the symptoms coincided with failure in the performance of cognitive tasks. Goldstein interpreted both this failure and the other symptoms as immediate manifestations of anxiety. According to this view, anxiety itself is a kind of failure, rather than a secondary reaction to failure. The failure of Goldstein's
patients resembles the insufficiency and powerlessness of the patient in the interview. This insufficiency and powerlessness represents a tendency which is opposed to the urge of self-preservation. This means, ultimately, that anxiety transcends the domain of emotions. Anthropological psychiatrists consider anxiety to be the expression of a fundamental and universal disintegrating tendency in human life.

DESCRIPTIVE PSYCHOPATHOLOGY: OTHER DISTINCTIONS

We will now explore some other distinctions drawn with respect to the subjective experience of anxiety. Let us begin with the well-known distinction between phobic fear, obsessive-compulsive fear, and panic.

Phobic anxiety consists of an unreasonable and inappropriate fear, which is associated with situations of a particular type and often leads to the avoidance of that situation. The family of phobias is usually divided into three groups: agoraphobia, social phobia, and specific phobias. Specific phobias in their turn are subdivided into phobias related to animals, physical harm (blood, injections, bodily injury), natural environment (heights, storms, water), and other specific situations (airplanes, elevators, closed spaces, and situations that may lead to contracting an illness).

The term agoraphobia is somewhat unfortunate because of its association with fear of streets. Westphal (14), however, to whom we owe the term agoraphobia in its technical sense, already recognized that his patients were not afraid of streets and squares as such. Theirs was rather a fear of anxiety itself, an anxiety that may only later be linked to situations of a particular type. DSM-IV specifies these situations as “places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack or panic-like symptoms” (15). The “panic-like symptoms” in this definition refer to any of the 13 symptoms listed for panic attacks or to other symptoms that may be incapacitating or embarrassing (e.g., loss of bladder control). These definitions not only illustrate DSM-IV’s emphasis on the close relationship between panic and agoraphobia, but also the irrelevance of distinguishing between internal and external stimuli. According to some older views, phobias are characterized by fear of external stimuli. However, recent research has suggested that fear of interoceptive sensations may be a central element in many cases of panic disorder with or without agoraphobia (16,17). The concept of disease phobia is too narrow to encompass all these cases. Agoraphobics do not avoid their bodily symptoms, but the panic and helplessness that ensue from being exposed to these symptoms. In the same vein, hypochondriasis and panic disorder can be differentiated on the basis of the nature
of the fear and the behaviors that accompany this fear. Hypochondriasis is exclusively related to the fear of having (or the idea that one has) a serious disease. This fear may have an obsessional quality and often leads to medical “shopping.” Hypochondriacs often show a “frustrating combination of demanding neediness and help rejecting refractoriness to treatment” (18).

Social phobia is characterized by DSM-IV as a “marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by other others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing” (15). Social phobics and agoraphobics both fear their symptoms of anxiety. The differentiation between the two conditions is not based on the nature of these symptoms, but primarily on the patient’s assessment of the nature and the reason of the fear: possible scrutiny and/or humiliation in social phobia versus no escape/no help in agoraphobia. It must be noted, however, that this distinction sometimes does not suffice (19). There are, for instance, patients who feel both humiliated by and helpless when confronted with their symptoms. DSM-IV rightly adds that in these cases the role of the companion may be useful in differentiating between social phobia and agoraphobia. Agoraphobics typically prefer to be companied by a person who is trusted, whereas social phobics feel scrutinized irrespective of whether they have a companion or not. It has also been suggested that a distinction between primary and secondary social phobia might be useful here (20, 21). Secondary social phobia would occur in the setting of panic disorder and refer to fear of embarrassment or humiliation were the patient to have a panic attack in front of others. Primary social phobia would be related to immediate social concerns and not to the embarrassment that secondarily results from the exhibit of symptoms of panic. As indicated above, DSM-IV has not gone so far by including anxiety symptoms as a potential object of social phobic fear.

Obsessions are “persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress” (15). Compulsions are “repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress” (15). They attempt “to ignore or suppress [their] thoughts or impulses or to neutralize them with some other thought or action” (15). In short, phobics avoid and obsessives try to undo. Semantic clarity, however, does not preclude some overlap between phobic and obsessive fears. Avoidance and undoing may come very close to each other. Fear of dirt or contamination with feces or sperm may provoke, for instance, both excessive washing rituals and avoidance of situations in which contamination cannot be undone (e.g., sexual intercourse, rooms in one’s home which cannot be cleaned because of lack of time). There are
situations in which there is simply too much to undo. Aggressive obsessions may lead to phobic avoidance of knives. Phobic fear, on the other hand, may have an obsessional quality, a quality denoted by the old German term for phobic fear—Zwangsbeüchtung ("obsessional fear").

Panic is described by DSM-IV as "a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of ‘going crazy’ or losing control are present" (15). DSM-IV lists 13 of these bodily and cognitive symptoms, 4 of which are needed to meet the criteria for panic disorder. Limited-symptom attacks meet all other criteria but have fewer than four symptoms.

There has been a lot of discussion about the presence or absence of situational triggers in panic disorder. Part of this discussion was generated by the results of naturalistic "monitoring" and "experience sampling" studies (22-24). Margraf and colleagues (24), for instance, comment that panic patients sometimes fail to perceive environmental triggers. Many attacks that were classified as spontaneous occurred in classical "phobic" situations. Patients also endorsed a greater number of symptoms retrospectively than in their diary.

DSM-IV uses a threefold distinction, originally defended by Klein et al. (25; see also Ref. 26), between unexpected (or uncued), situationally bound (or cued), and situationally predisposed attacks. Unexpected attacks occur spontaneously "out of the blue." Situationally bound attacks occur "immediately on exposure to, or in anticipation of, the situational trigger or cue." Situationally predisposed attacks are "more likely to occur on exposure to the situational trigger or cue and do not necessarily occur immediately after the exposure" (15). The reason for this distinction is that the strong criterion of unexpectedness (DSM-III) did not appear to be appropriate for many attacks in case of panic disorder. Situational cues and the anticipation of these cues may predispose to panic attacks without immediately provoking them. This is why situationally predisposed attacks were admitted to support the diagnosis of panic disorder. Situationally bound attacks typically occur in cases of social phobia and specific phobia.

DSM-IV states that there should have been at least two unexpected attacks and that at least one of those attacks should have been followed by (1) "persistent concern about having additional attacks," (2) "worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, ‘going crazy’)," and/or (3) "a significant change in behavior related to the attacks" (15). In spite of these refinements in the definition of panic disorder, there will always be borderline cases in which it is difficult to differentiate between panic disorder, on the one hand, and social phobia, specific pho-
bia, somatization disorder, and obsessive-compulsive disorder, on the other hand (27). The patient may, for instance, have had a number of unexpected attacks in the distant past, but does not at present show any “persistent concern” or “worry,” whereas the “significant change in behavior” is gradually diminished and changed into a phobic avoidance of a specific situation (e.g., tunnels). Other patients have a lot of symptoms, without reporting any subjective fear. Still others are clearly social phobic but suffer also from rare, uncued attacks. DSM-IV mentions four factors that can be helpful in these cases: the focus of fear, the type and number of panic attacks, the number of situations avoided, and the level of intercurrent anxiety (15). The more limited the focus of the fear, the lower the number of situations and the number of panic attacks, and the lower the level of intercurrent anxiety, the less probable it is that a diagnosis of panic disorder is warranted. In panic disorder, fear is primarily focused on the occurrence of panic attacks.

The current emphasis on descriptive accuracy does not rule out the possibility that there are anxiety-related subjective phenomena, which were lost in the recent debates on classification. Depersonalization and derealization, for instance, have almost disappeared as anxiety-related phenomena (except as symptoms of panic disorder), in sharp contrast to the prominent role they played in famous descriptions of men like Roth and Janet. The phobic anxiety-depersonalization syndrome, which was described by Roth in 1959, was a traumatically induced combination of phobic, pseudo-hallucinatory and paniclike symptoms, which today probably would be subsumed under the heading of both posttraumatic stress disorder and panic disorder with agoraphobia (28). Depersonalization was a salient feature of this syndrome.

In Janet’s descriptions of the psychasthenic state, which, unfortunately, are almost forgotten today, feelings of unreality and depersonalization also play a major role. Common to all psychasthenic patients, says Janet, is a disturbance in psychological functioning, the so-called psychasthenic state. This state is characterized by what he calls a “sense of incompleteness” (sentiment d’incomplétude), a diminishing of “the sense (or function) of reality” (la fonction du réel), and exhaustion (29). The sense of incompleteness refers to a pervasive feeling of ineffectiveness. Whatever one does, it seems useless and not to come to an end. Doubt, hesitance, rumination, depersonalization, feelings of doubleness and unreality, restlessness, and apathy belong to the many manifestations of this state. With regard to the diminishing of “the sense (or function) of reality,” Janet refers to a kind of mental presence that enables one to be alert, spontaneous, and effective. The diminishing of this so-called coefficient of reality is particularly important in the domains of voluntary action, attention, and perception (29). According to Janet, psychasthenic patients show subtle imperfections in concentration and in other “synthetic” mental functions. As a
consequence of this "lowering of psychic tension" (abaissement du niveau mental), routine daily activities may be disrupted.

From here, it is only a small step to the changes in the quality of the sensory appreciation of the world. Think, for instance, of the typical changes in the perception of space in agoraphobia. Landis (2) cites the following passage from W. E. Leonard's autobiographical book The Locomotive-God, which deals with the author's lifelong agoraphobia:

Home again becomes immeasurable distance, only more immeasurable. And the distance of three blocks to the railway-bridge girders is, I feel, an infinity of street in the sun. I totter. I fly. I open my shirt to get air on my bare chest. There is a white hitching-post by the gutter near the end of the block. My imagination creates this as its goal, as its refuge.

Open spaces like streets and squares may generate a feeling of infinite distance. Objects like railway-bridge girders and hitching-posts function as safety signals. The world of the patient with agoraphobia is full of these warning and safety signals. Some agoraphobics prefer darkness when leaving home. Others use sunglasses in order not to see the "blockages" which could keep them from the safety of home. Some of them describe the world outside as uncanny and alienating, as a paralyzing vacuum destroying all initiative and self-confidence. This is in contrast to the world of obsessive-compulsive patients, which is full of objects and situations that could run out of control. Obsessive-compulsives feel almost continuously at the edge of chaos. They are possessed by "demons," which are at the point of overwhelming them—the demons of dirt, sperm, feces, bad odors, physical harm, or microorganisms. Their rituals may result in an alteration of time-perception. The endless repetition of thoughts and acts leads to an altered or decreased sense of temporal change (30). Their world is transformed into an imaginary world, in which temporal continuity is fragmented by the repetition of fixed behavioral sequences and thoughts that gradually take the place of real-world sorrows and occupations.

ANXIETY AND PSYCHOSIS

One of the most neglected topics in descriptive psychopathology is the subject of psychotic anxiety (31). Of course, the frequent occurrence of anxiety in the context of psychosis has not gone unnoticed. It was, for instance, Wernicke who already at the end of the nineteenth century coined the term anxiety psychosis to denote a psychopathological entity characterized by such intense anxiety that frightening hallucinations, delusions, and delusory ideas were the result (32). Many clinicians, then and now, consider anxiety as a consequence of all kinds of cognitive disturbances. Wernicke challenges this view by arguing for the primacy of anxiety. The ensuing debates not only centered around this theme,
but also around the nature of psychomotor agitation. According to some clinicians psychomotor agitation was to be considered as a prominent symptom of anxiety psychosis; others saw it as a secondary phenomenon or as part of agitated melancholia or manic-depressive illness (33–35).

With the virtual disappearance of the term anxiety psychosis from clinical usage, interest in anxiety symptoms in the context of psychosis also faded. However, two important, unfortunately almost forgotten, publications are worthy of mention: Störring’s *Zur Psychopathologie und Klinik der Angstzustände (On the Psychopathology and Treatment of Anxiety States)* (13) and Conrad’s *Die Beginnende Schizophrenie (Incipient Schizophrenia)* (36). Both works emphasize the fundamental significance of anxiety in the origin of psychosis. Both go on to describe a period of depersonalization, anxiety, and anxious mood, which often precedes the onset of psychosis. Conrad uses the term “tremat” to denote this anxious delusory mood. Störring describes how this anxious delusory mood can lead to so-called objectivation of anxiety (nowadays called projection). Feelings of anxiety are no longer experienced internally, but transformed into perceptions of a dreadful and mysteriously changed world. Feelings lose their natural bond with the I. As a consequence, they take on an enigmatic and indeterminate character. While the patient does not necessarily experience anxiety subjectively, the world nevertheless changes in an obscure way and appears to be terrifying, threatening, and gruesome.

**THE COGNITIVE COMPONENT**

It is interesting to note that the surge of interest in the cognitive component of anxiety initially resulted from a fascination with the nontransparency of the feeling of anxiety, one of the main themes of this chapter. Beck et al. (37) considers it an unfortunate tautology that anxiety neurosis is defined as a disturbance in which the source of anxiety is unknown. “Since, by definition the patient is unaware of the source of his anxiety, the clinical investigator is unlikely to make a thorough examination of the content of the patient’s phenomenal field.” Building on observations collected during psychodynamic psychotherapy, they hypothesize that there are idiosyncratic thoughts, images, and thinking patterns specific to each neurotic disorder. The thoughts and images may last only a short time. In the case of “anxiety neurosis” this idiosyncratic ideation mainly concerns the anticipation of physical harm (becoming sick, being attacked or involved in an accident) or psychosocial trauma (humiliation, rejection). Beck and coworkers (37) indeed found that 90% of their 24 patients had vivid visualizations centering around the theme of danger prior to their anxiety attack. All patients had danger-related cognitions. The investigators were struck by the unique, personal content of the fear in each patient: “These per-
sonal variations often shed the most light on the relation between the patient’s mode of integrating his experiences and the arousal of anxiety” (37). Beck and coworkers later formulated the notion of “personal domain,” representing the area of a person’s vital interests (38,39). The study of Hibbert (40) yielded broadly similar findings, although the fears of patients without panic attacks were less readily classified as “personal dangers.”

The same picture emerges from the study of Argyle (41), in which DSM-III criteria were used. He found a difference in the focus of fear between sudden and gradual-onset anxiety attacks, irrespective of whether the attacks occurred in the context of panic disorder or another anxiety or (even) affective disorder. Sudden attacks were associated with cognitions referring to immediate catastrophe, such as dying, fainting, collapsing, and going crazy. Cognitions of gradual-onset anxiety were related to everyday worries, traveling, being alone, other illnesses, and social embarrassment. Most of these cognitions concerned future events. During sudden attacks, the range of cognitions was narrowed and attention appeared to be directed inward to the mental or physical catastrophe that was in the process of occurring. These results, however, do not allow one to draw unequivocal conclusions about the relationship between the type of cognition or sensation and the type of anxiety disorder. Investigations focusing on this relation have provided only meager results. Hoehn-Saric (42), Anderson et al. (43), Barlow et al. (44,45), Cameron et al. (46), and Borden and Turner (47) indeed found slight differences in the symptom profiles of panic disorder patients with or without agoraphobia, generalized anxiety disorder, and a number of phobias. But these differences turned out to be insufficient to establish a diagnosis of anxiety disorder. Overall intensity of the symptoms also did not appear to be of diagnostic relevance. Finally, nonfearful panic disorder was discerned as a subgroup of panic disorder, suggesting that cognitions are irrelevant for a subgroup of panic disorder patients (48). The most consistent finding in all these studies is the presence of cardiovascular and respiratory symptoms in panic disorder (see Ref. 49).

As a consequence, the focus of cognitive research has shifted from correlations between descriptive entities, such as those mentioned, to explanatory constructs like anxious apprehension (50,51), fear of bodily sensations (16,52), and fear of fear (53,54). Fear of fear in its turn has been divided into anxiety sensitivity (55–57) and expectancy (or predictability) (58–63). Chambless and Gracely (17) mention fear of bodily sensations as a component of fear of fear. Uncontrollability has been suggested to represent an important dimension of posttraumatic stress disorder (64).

Recent research suggests that there are at least three fundamental fears: anxiety sensitivity, fear of negative evaluation, and injury/illness sensitivity (63). These fundamental fears appear to be factorially distinct and account for 22–41% of the variance of common forms of fear and trait anxiety (65). Taylor
(65) suggests that the unexplained variance is mainly due to idiosyncratic factors in fear acquisition (e.g., aversive and traumatic experiences).

Finally, worry has been investigated as a central phenomenon in generalized anxiety disorder. Results of these investigations suggest that worry primarily involves thought, rather than imaginary, activity (66). Generalized anxiety disorder patients do seem to fail in terminating their worries (67). It has been suggested that worry and (obsessive) checking are functionally similar (68).

**CLOSING REMARKS**

From this overview, one can only conclude that there is an enormous diversity in the phenomenology and subjective experience of anxiety. We have seen that this diversity to a large extent can be explained by idiosyncratic factors in fear acquisition. This might imply that our expectations about future research on the categorical and/or factorial separateness of different types of anxiety should remain modest. However, the problem of diversity—and of comorbidity—may also be a reflection of shortcomings in our methodologies and in the theoretical constructs on which these methodologies are based.

The term anxiety is typically a lay construct. Science transforms this construct into one of the “components” of anxiety: verbal report. This transformation of subjective experience into verbal report, however, easily results in isolation and decontextualization of the feeling aspect of anxiety (69):

If a client reports that [he or she has] acute attacks of somatic distress and a feeling of doom, this is not regarded as the verbal/subjective component of a panic disorder but an item of behavior that should be interpreted structurally (in relation to the presence or absence of other behaviors in the repertoire), contextually (as an act whose meaning derives from a specific context) and functionally (in relation to eliciting and maintaining events).

The subjective meaning of a particular feeling state should in other words be primarily derived from behavior patterns and the contexts in which these behavior patterns develop (see also Ref. 70). Classification of verbal report may be too limited an approach to serve as an entry to the scientific understanding of the subjective dimension of anxiety.

This is not meant to detract from the merits of verbal report in the clinical situation. Here, however, the hazards of isolation and decontextualization can be neutralized, particularly by the carefully conducted clinical interview and by focusing on the biographical embeddedness of the patient’s complaints. As was mentioned in the introduction, pathological forms of anxiety must be seen as products of a learning history.

It is interesting to note how the earlier descriptions, which were often heavily loaded with psychodynamic terminology (see Ref. 71), have made room for
descriptive precision, such as required by authoritative classification systems like DSM and ICD. This is not to say that these classification systems, in particular the successive editions of the DSM, are totally nontheoretical. A category like panic disorder cannot even be thought of without the numerous pharmacological and challenging studies that laid the basis for its existence as a separate diagnostic entity. Ultimately, phenomenological description and theoretical explanation cannot be kept apart.

If all this is taken into consideration, one can only conclude that we are in need of a conceptual framework in which different approaches to the phenomenon of anxiety are ordered systematically according to their viewpoint (molecular, physiological, behavioral, cognitive, social, and subjective) and their level of abstraction (from pure description to approaches with a high level of abstraction). With such a conceptual framework it would be possible to diminish the gap between mere description of subjective mental states on the one hand and explanation by high-level theoretical constructs on the other hand.

Throughout this chapter we have been concerned with the nontransparency of the feeling of anxiety. Many authors challenged the view that this nontransparency must be attributed solely to biological causation. Psychoanalysts and cognitive therapists pointed out that meaningless and objectless anxiety may become meaningful and transparent in the course of psychotherapy. Anthropological psychiatrists went a step further by stating that anxiety, rather than being exclusively related to internal or external danger, must be conceived as the counterpart of the human urge for self-realization. Anxiety, ultimately, refers to a domain that is beyond that of emotion. This insight should not be played off against other approaches, in particular the biological approach. For the frustration of the urge for self-realization is expressed in all domains of human functioning, the biological domain included.

REFERENCES

