On anxiety, a relational somatic perspective

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Abstract

In this paper, I will discuss anxiety from object relations and somatic perspectives. My primary concern is with what Freud called signal anxiety which is an uncertain feeling that serves as a warning sign that harm can occur in the future. I will introduce a simplified object relations theory. Based on this theory, I will partition anxiety into persecutory, depressive, and existential anxieties, which I will discuss thoroughly. The presented theory points to different somatic relational therapeutic techniques based on neuroscience, attachment theory, and object relations for treating persecutory, depressive, and existential anxieties. I will also discuss case studies to show the applications of the theory and techniques presented.

Keywords: Anxiety, attachment, limbic brain, limbic regulation, limbic resonance, limbic revision, neuroscience, neurotic anxiety, object relations, signal anxiety.

Anxiety – an introduction

We feel anxiety every day, and as such it can be considered as a normal part of life. There is always something to worry about. Anxiety can also be a motivating force, but too much anxiety can be debilitating. Freud (1989) describes anxiety as an affective state, something that is felt. He also categorizes anxiety as either primary anxiety which is triggered by a traumatic event and has an immediate target (fear), or signal anxiety which can involve a more uncertain feeling and can serve as a warning that harm could occur in the future (LeDoux, 2015).

Freud (1989) believed that anxiety is the result of the need to keep the impulses based on traumatic memories and thoughts out of consciousness. The defense mechanism of repression is employed to achieve this task. If repression fails, the painful impulses may reach consciousness and the result will be "neurotic anxiety." Freud's goal was to bring the causes of these painful impulses, through psychoanalysis, to consciousness and thus to reduce or eliminate the neurotic anxiety (LeDoux, 2015).

Existentialist philosophers such as Heidegger and Sartre presented a different view of anxiety. Existentialists consider anxiety as an important and inevitable part of life. Existentialists view an individual as a free and responsible agent capable of making choices and decisions through acts of will. They believe that anxiety is the result of having choices and having to make decisions. Existentialists thus focus more on coping strategies since they believe that anxiety is an integral part of life (LeDoux, 2015).

In this article, I am only concerned about what Freud called signal anxiety which is triggered by past memories. Many neuroscientists as well as psychologists believe that memories are represented by associative neural networks which are structures in which various aspects of memory are represented separately and linked together (LeDoux, 1996). For the memory to form the associative network, it must have reached a certain degree of activation which is dependent on the constituent components of memory as well as the weight of each component. The weight of the components is dependent on the cues that were present during the learning process and are also present during recall. These cues in many cases are emotions associated with the components of memory. Thus, as a given component of memory is activated due to presence of a given cue, the activation of the full associative network is also facilitated. The cues in this case may be signals from brain and the body (emotions) that indicate that we may be in the same emotional state as during the time of formation of memory (LeDoux 1996). At this time, it is also particularly important to emphasize that memories are reconstruction of events at the time of recall, and thus our emotional state can influence the way the recalled memory is remembered. And the converse is also true in that memories are recalled and remembered best when one is in the same situation or emotional state (LeDoux, 1996). Not all aspects of an experience are remembered in the same way, and emotions may affect the recall of certain aspects of memory more than others. In general, the memory of the more emotionally significant aspects of an experience is remembered better than the more emotionally neutral aspects of memory (LeDoux, 1996).

With the above introduction to memory encoding and recall, let us now discuss what happens in the brain as it is exposed to a stimulus. All the sensory nerves (except for olfactory nerves) end up in the thalamus and are then relayed to various parts of the brain. The thalamus

(which has two halves) can be thought of as brain's switch board or information hub. After sensory input (from eyes, ears, touch, etc.) is received and processed by thalamus, they are sent to various cortices and to a brain structure called the amygdala. The amygdala is an almond size structure (one in each side of the brain deep within the limbic system) which is responsible for appraisal of stimuli and evaluation of emotional significance of the stimuli. Van der Kolk (2014) calls the amygdala the "smoke detector" of the brain. If the amygdala's evaluation of a stimulus is perceived as presence of danger, then it triggers the release of various (stress) hormones including adrenaline and cortisol, resulting in activation of the sympathetic nervous system, preparing for fight/flight or in certain situations the freeze response. Once the amygdala deems that danger has passed, the body should return to its baseline state (Shahri, 2017).

Let us now turn our attention to anxiety from the perspective of object relations theory. In the following I will begin by giving a brief introduction to object relations theory.

An introduction to object relations theory

With the birth of an infant their journey of life starts. The first period in the life of the neonate, which is normal autism (Mahler, 1975), autoerotic phase (prior to primary narcissism) (Freud, 2012), or Schizoid stage (Lowen, 1994) begins at birth. During this stage which in terms of object relations is objectless, the infant's drives are focused on himself (autoerotism). This period lasts about a month. At the end of this period the infant, if unscathed, has formed a relatively integrated image of his body, for example he knows that his limbs belong to him. At this point, the beginning of the second month of life, which corresponds to the symbiotic stage (Mahler, 1975), or the first half of the oral stage (Lowen, 1994), the infant faces existential anxiety and fear (primary anxiety – Freud). In terms of object relations, this period is pre-object during which the infant's drives are mostly focused on the need satisfying part-objects (the breast, etc.), and the infant experiences his mother's functioning as part of himself (symbiotic stage) (Mahler, 1975).

Full object relations begin at the end of the symbiotic phase which ends around 5 months of age. The infant begins to differentiate between himself and his mother and begins to distance himself from her by pushing her away when held in her arms. This is Mahler's differentiation subphase (Mahler, 1975) or the second half of the oral period (Lowen, 1994). At this point the infant fears not having the object (mother) in his vicinity and at the same time wants to differentiate from her. The drives during this and subsequent periods are focused on the object for support and safety as well as exploration of the environment. Please note that in either of these two cases, the drives serve to reduce the uncertainty and unpredictability within the infant by seeking proximity and outside of himself by exploring his environment (Shahri, 2022). The needs of the infant are partially met and partially frustrated. The frustration of the infant's needs results in higher tension and uncertainty within the infant. The infant, in order to gain some control over his environment and to be able to predict it (reduce unpredictability), must adapt to this situation and consequently form neural pathways that resemble those of his mother [unsatisfying/frustrating object]. Thus, in effect he internalizes his 'bad' mother in order to reduce the uncertainty (anxiety) within his environment, and in doing so his immediate needs for his mother are reduced as well. The 'bad' internalized mother has two facets, on the one hand it

allures but does not satisfy and on the other hand it frustrates and rejects! This is an intolerable situation and the infant, in order to control the situation, splits the internalized 'bad' mother into the needed or exciting object which allures but does not satisfy, and the frustrating or rejecting object. The infant will seek the exciting object (EO) throughout his life seeking a fuller human connection, in order to reduce the unpredictability within his unitary psychosomatic structure. The ego maintains a libidinal attachment to this internalized exciting object, resulting in a split within the ego. Fairbairn (1952) calls the endopsychic structure resulting from this split, the libidinal ego. Guntrip (1994) writes: "The libidinally exciting but unsatisfying object arouses and maintains in the infant a state of unrelieved need and craving. This intolerable aspect of experience is repressed in the form of an internal bad-object relationship between an intensely needy and never satisfied libidinal ego and an intensely stimulating but unsatisfying exciting object" (p. 110).

Please recall that at the end of the differentiation subphase (Mahler, 1975) or the end of oral stage (Lowen, 1994), the infant's drives shift more toward exploration of his environment since he has developed the ability of locomotion. The child at this point moves further away from the mother and is increasingly absorbed in his own activities and less aware of his mother. This period coincides with Mahler's practicing period (Mahler, 1975) or Lowen's narcissistic stage (Lowen, 1994). At this point the infant's explorative drives may face environmental negativity and rejection. His drives may be thwarted by the mother (bad object), which in turn increases the uncertainty in the infant by increasing his anxiety as the infant feels that his exploratory drives are blocked and that his connection with the still needed mother has weakened. In order to reduce the unpredictability (anxiety) the child chooses a similar strategy to before. He forms neural pathways in his brain based on his experience with his mother and in effect will block and redirect his own drives to conform to his environment and the limitations imposed on him by his mother (bad object). That is to say that he internalizes and identifies (identification is a stronger form of internalization) with his mother in order to reduce the uncertainty of his environment and gain some level of control over it. This is, as I alluded to above, the rejecting and frustrating aspect of the 'bad' object (rejecting object - RO). Like the previous case, the ego maintains a libidinal attachment to the rejecting object which results in a further split within the ego. Fairbairn (1952) calls this endopsychic structure, the anti-libidinal ego, or the internal saboteur. Guntrip (1994) writes: "The libidinally rejecting object, whether passively rejective, indifferent, neglectful, or actively rejective, angry, aggressive, arouses fear and anger in the child. This intolerable aspect of experience is repressed in the form of an internal bad object relationship between a rejecting object which presents itself as a persecutor, and an ego that escapes persecution by abandoning the position of libidinal need and demand and finding safety in identification with the rejecting object" (p. 110).

Fairbairn contended that the good aspects of objects are not internalized but are simply enjoyed resulting in good ego development (Guntrip, 1994). It is important to note that new neural pathways also form based on the good experiences and satisfying relationships with the good objects. These newly formed neural pathways, based on good experiences with the object, serve as ways of keeping uncertainty low. I suggest that these newly developed neural networks also represent a form of internalization as they resemble those of the good object. This phenomenon is observed in therapy, as the client's brain, through their good experiences with the therapist, forms new neural pathways that are like those of the therapist, since we know that the

brain wires through experience. These newly formed pathways support new coping mechanisms and new effective approaches to life's challenges, thus reducing unpredictability and uncertainty, and increasing a sense of safety.

However, residuals of the original drives remain. This is the "I" that relates to the environment and to people in the outside world. Fairbairn (1952) called this endopsychic structure, the central ego (CE). Please note that the ego forms as a result of drives going through and being shaped by the reality principle. The ego is mostly conscious but may also contain unconscious elements. Ego, albeit, in limited form, still contains some aspects of the original drives. Guntrip (1994) writes: "The one thing that the child cannot do for himself is to give himself a basic sense of security since that is a function of object relationship. All that can be done is for the Central Ego to seek to become independent of needs for other people" (p.141). This is an impossible situation as the central ego is weak and ungrounded as some of its energy has been consumed, limited, and shaped by the libidinal and antilibidinal egos. Its approach to the environment and objects may be tentative and cautious. The increased uncertainty and lack of grounded-ness of the central ego experienced as possibly partial loss of the sense of self, due to its weakness and ungroundedness can be, to some extent, ameliorated by seeking mirroring self-objects, idealizing self-objects, or twinship self-objects (Kohut, 1971), where self-object is the experience of an object (person) as part of the self. This is the narcissistic line of development that self-psychology (Kohut, 1971) focuses on. Please note that the tentativeness and cautiousness of the central ego is related to perceived higher unpredictability and uncertainty within the individual's environment and his relative inability to approach and withdraw effectively. The individual can reduce this uncertainty and unpredictability by finding objects that mirror him and reflect a sense of self-worth and self-value back to him (mirroring self-objects), or by finding those people who make him feel calm and comfortable (idealizing self-objects), or by finding those who give him a sense of likeness (twinship self-objects) (Kohut, 1971).

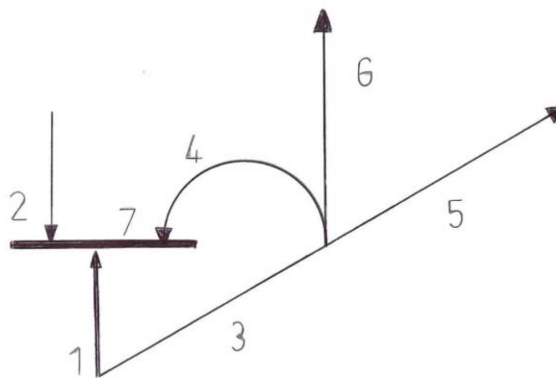

Figure 1. Relational trauma

In Figure 1, I depict the process of relational trauma. The presented model is adopted from Wilhelm Reich (1980) and clarifies the process of relational trauma. A simpler form of this diagram has also been discussed in detail by Hilton (2008). In this diagram, segment 1 represents the unitary drive. The drive may face frustration, rejection, or environmental negativity represented by segment 2. Segment 3 represents the new direction that the drive takes. Identification with the rejecting aspects of the object is represented in segment 4 (antilibidinal ego), and the seeking of the needed and exciting aspects of the object is represented in segment 5 (libidinal ego). Segment 6 is the representation of the central ego. The muscular armor which keeps the original drive in-check is represented by segment 7.

The strategy that was necessary in childhood to reduce the uncertainty within the child's psyche acts in the opposite direction, for the most part, during adulthood. Fairbairn (1952) contended that for the client to risk the release of bad objects from his unconscious, he had to feel safe within the therapeutic environment and to see the therapist as the good object, so that he can become vulnerable (not function from his defenses) for his brain to form new neural pathways. He can then overcome his resistance to releasing the bad objects from his unconscious. The release of the bad object and the internalization of the good object support the true self (related to segment 1 in Figure 1). The True self (segment 1 in Figure 1) may replace the endopsychic structures, although residuals always remain. Recall that Wilhelm Reich (1980) asserted that psychoanalysis is about consistent analysis of transference and resistance. Transference and resistance are nothing but the persistent activation of the old neural networks. Consistent analysis of transference and resistance is necessary for successful release and dissolution of the endopsychic structures. This is the case since formation of new neural pathways is based on the new experience with the therapist. Once the bad objects are released from the unconscious, the conflict between the true self (segment 1 in figure 1) and internalized bad objects are diminished, thus reducing the uncertainty related to this conflict which might have resulted in anxiety. I must, however, emphasize that once the internalized bad objects weaken and are released; the client may feel strong (existential) anxiety which is caused by the loneliness (void) stemming from the loss of the internalized bad objects as well as going back to the earlier (childhood) state right before the time that internalization of bad objects took shape. This is akin to replacing one anxiety with another! The anxiety associated with misattunement occurring early in childhood was replaced with the anxiety corresponding to conflict between the true self and the internalized bad objects which was less threatening. At this stage of healing, the presence of the therapist is of utmost importance for the repair to take place (Shahri, 2021). Once the internalized bad objects are released from the unconscious and the anxiety related to their release has been diminished with the help of the empathic and present therapist, the client may experience a multitude of affects. Their body may expand, they may spontaneously reach out for contact, they may feel anger, hate, love, sadness, grief, etc. The therapist must be present to receive the client and remain present with them as they go through these affects. The client will then be grounded in their contact and connection with the therapist and will use the therapist as a secure base for making contact with others, their environment, and the world without anxiety.

It can thus be seen that it is not the weak central ego that must be bolstered to compensate for the loss of the endopsychic structures, but it is the true self that must be empowered to find its expression. Regarding the central ego, Guntrip (1994) indicated that what needed to be strengthened was not the central ego, but the client's primary nature (related to segment 1 in

Figure 1) which was repressed and arrested in development (Guntrip, 1994). At this point the real self, for the most part, replaces the central ego which in the past needed the self-objects to maintain a weak sense of self.

The interested reader should note that my description of object relations differs slightly from the way Fairbairn (1952) originally formulated it. It is also noteworthy to indicate that the antilibidinal ego essentially corresponds to the superego, in that they are both related to the internalized bad objects.

Anxiety – an object relations perspective

Anxiety is a reaction to danger (Freud, 1989), and anxiety as an affective state can only be felt by the ego (Freud, 1989). Freud (1989) writes: "These three instances can be reduced to a single condition namely, that of missing someone who is loved and longed for. … and now it seems that longing turns into anxiety" (p. 66). Elsewhere, Freud (1989) writes: "... what the ego regards as the danger and responds to with an anxiety-signal is that superego should be angry with it or punish it or cease to love it" (p. 70). I must emphasize that prior to the formation of full object relations, the anxiety is mainly undifferentiated. In what I will discuss next, I assume that the child has established and formed full object relations which necessitates a certain degree of ego development.

Melanie Klein (1975) introduced the concepts of depressive anxiety and persecutory anxiety. Klein (1975) writes: "To such fears are added those of losing his loved objects; that is to say, the depressive position has arisen. … I put forward the suggestion that the introjection of the whole loved object gives rise to concern and sorrow lest that object should be destroyed, and that these distressed feelings and fears, in addition to the paranoid set of fears and defenses, constitute the depressive position" (p. 348). This is the depressive anxiety. For the growing infant, the fear of losing his loved object triggers the anxiety and feeling of having lost his loved object results in the depressive position; hence the depressive anxiety. Klein (1975) further writes: "The first set of feelings and phantasies are the persecutory ones, characterized by fears related to the destruction of the ego by internal persecutors" (p. 348). To summarize, Klein presented a distinction between depressive anxiety and persecutory anxiety. She indicated that depressive anxiety is related to internal loss of good objects, and persecutory anxiety is related to internal attack by bad objects (Guntrip, 1994).

It is clearly seen that the persecutory anxiety is related to the antilibidinal ego and its persecutory nature, and the depressive anxiety is related to the libidinal ego and its fear of loss of the exciting object and concomitant depressive feeling. The persecutory anxiety is typically experienced by the client typically as expectations of being criticized, admonished, or punished. And the depressive anxiety is typically experienced as intense longing for an object with concomitant fear of losing the object. To these, I would like to add the existential anxiety which is related to the central ego. Recall that the central ego is the residual of the original ego which is weak and seeks to be independent and not need others. It is precisely the weakness of the central ego and its striving for independence that result in existential anxiety. The existential anxiety usually manifests itself as fear of death and dying as well as hypochondriasis. Kohut (1971)

writes: “Thus the analogy between the patient’s present hypochondriacal concerns and the vague health worries of a lonely child who feels unprotected and threatened can be drawn, facilitating the patient’s grasp of the deeper meaning of his present condition as well as of its genetic roots” (p. 137).

So far in this article I have discussed persecutory anxiety, depressive anxiety, and existential anxiety and their origins and etiology. It is seen that these anxieties result due to suboptimal parent-child relationships, and parental shortcomings in not responding to the infants’ needs for love, support, and protection.

Case studies - examples

Sue was a client in her late 50’s who came to see me regarding her anxieties. She had fears of not doing what was assigned to her well, and as a result would get very anxious. This aspect of Sue’s anxiety was clearly of a persecutory nature. She also was overly concerned about the wellbeing of others, especially those close to her. The slightest negative remark from the people that she was close to would make her very anxious followed by depressed feelings. We analyzed her anxiety, and it became clear to her that she was concerned that she might lose the people who were close to her and that if this state continued, she would feel that she had lost them which made her depressed. This aspect of Sue’s anxiety was clearly of a depressive nature. Sue grew up in an emotionally impoverished environment in which she was expected (under the threat of punishment or threat of withdrawal) to be a “good” girl and do what was expected of her. Her mother was also not fully emotionally available to her. Her mother allured and excited but did not satisfy. Sue was seeking the exciting objects in her life but unfortunately, ended up with those who were not emotionally available to her, remarkably like her mother. Sue clearly had both persecutory and depressive anxieties.

Betty was a 40-year-old client, who suffered from mild hypochondriasis. Betty was an educated woman and did not believe in religions. She also had a history of abuse early in her life. The core of her being was under attack early in life. She had the fear of getting cancer and dying, which made her very anxious. This anxiety was, at times, strong and debilitating. At an existential level, she felt very alone with no support which made her very anxious. Betty’s anxiety was clearly existential anxiety.

Charlie was a man in his late 30s who was educated and not religious. Charlie had mild depression with concomitant anxiety. He was taking medications for his depression and anxiety. He also had this vague sense of not knowing what the purpose of his life was. Charlie was sad, depressed, and anxious. He felt very alone! Charlie received some contact from his mother during his first year of life, but then after the birth of his sibling, this contact was withdrawn from him. He then had to mature quickly with no support. Charlie’s anxieties were of a depressive and existential nature.

Frequently, what we observe in clients is a combination of one or more of persecutory, depressive, and/or existential anxieties, as the above case studies show.

Treatment

It is seen that the persecutory and the depressive anxieties are both related to internalized bad objects. Therefore, the treatment must necessarily include the release of internalized bad objects. Fairbairn (1952) writes: “The bad objects can only be safely released, however, if the analyst has become established as a sufficiently good object for the patient. Otherwise, the resulting insecurity may prove insupportable” (p. 70). I alluded above that the client may not be able to risk the release of his bad objects unless they feel that they find in the therapist someone who loves and cares for them, does not judge them, empathizes with them, and is accepting. Guntrip (1994) writes: “If it is bad human relationships that make people emotionally ill, it can only be a good human relationship that can make them well again” (p. 401). However, transference and resistance in the therapy must be dealt with and worked through for the client to be able to become vulnerable in the presence of therapist before the client can risk the release of bad objects. I will address this next.

Let us consider a neuroscience perspective regarding the process of healing. A key to healing is for the client to be able to feel his vulnerability in the presence of the therapist. Due to [negative] transference, it is very frightening for the client to feel safe enough to trust the therapist and to become vulnerable in the presence of the therapist. The client generally functions and behaves from the old object relations upon which the transference is based. From a neuroscience perspective, transference is nothing but the activation of the old neural networks that were formed in relation to the early (old) internalized objects. And resistance is the persistent activation of these early (old) neural networks. Wilhelm Reich (1980) quite correctly and aptly indicated that psychotherapy is about consistent analysis and working through of the transference and resistance. Without the working through of the transference and resistance the client will repeat the old behavioral patterns through the activation of the familiar and old neural networks, and healing may not take place. When the client feels safe enough within their relationship with the therapist to work through the transference, they can become vulnerable and will drop their resistance. To paraphrase Fairbairn (1952), the resistance can only really be overcome when the transference situation has developed to a point at which the analyst has become such a good object to the patient that the latter is prepared to risk the release of bad objects from the unconscious.

During treatment, we are asked as therapists to survive the attacks of negativity that inevitably come as part of the individuation process. Winnicott (1971) writes:

> The subject says to the object: 'I destroyed you', and the object is there to receive the communication. From now on the subject says: 'Hello object!' 'I destroyed you.' 'I love you.' 'You have value for me because of your survival of my destruction of you.' 'While I am loving you, I am all the time destroying you in (unconscious) fantasy.' Here fantasy begins for the individual. The subject can now use the object that has survived. It is important to note that it is not only that the subject destroys the object because the object is placed outside the area of omnipotent control. It is equally significant to state this the other way around and to say that it is the destruction of the object that places the object outside the area of the subject's omnipotent control. In these ways, the object develops its own autonomy and life, and (if it survives) contributes to the subject, according to its own properties. (p. 120)

When the client becomes vulnerable in the presence of the therapist, that is when they no longer function from the old neural networks (transference and resistance) their limbic brain will be ready to form new neural pathways based upon their experience and relationship with the therapist. Over time, these new networks become stronger, and the old networks become weaker. Recall the Hebbian axiom that neurons that fire together wire together (Hebb, 1949). The weaker old networks do not disappear and under severe stress will get activated again, and it is this condition that the present work attempts to address. However, as the new networks get stronger, they govern, increasingly, the client's emotional response and behavior. This is the essence of healing in relational somatic psychotherapy from a neuroscience perspective.

It can be surmised based on my remarks that the release of bad internalized objects is a lengthy process, as it takes a long time for the therapist as a good object to be internalized, or said differently, for the client to form new neural pathways based on the relationship with the therapist. I have devised the following techniques to potentially speed up the process of releasing the bad internalized objects.

A technique

I ask the clients to be aware of their bodies. The awareness of the body can be thought of as the somatic correlate of the sense of self. I then ask the clients to stay in contact and connection with me while they are aware of their bodies. I instruct the clients that in order to feel their connection and contact with me, they need to feel the space between them and me and look into my eyes. Feeling the space between them and me can be seen as the somatic correlate of the connection (Figure 2). This step makes the clients aware of the presence of the “good object” which is felt at the somatic level. I ask the clients to maintain their connection with their body and with me, until I feel that they are no longer functioning from their attachment to their internalized bad objects, at least temporarily.

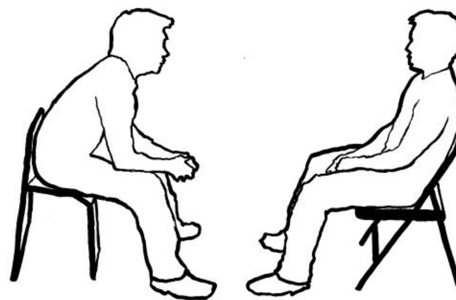

Figure 2. The release of bad objects

Internalization of the contact with the good object will occur over time and is a lengthy process. Once the contact with the good object is internalized the clients do not need the presence of the therapist (good object) any longer. In order to shorten the length of this process, I devised the following addition to the process described above, in which the client remains silent

and simply stays in contact with themself and with me. I must mention that the client must have reached a certain degree of trust within the therapeutic relationship to be able to become vulnerable (drop their defenses and resistance) for this step to be effective. I also indicated above that a certain level of ego strength is needed for these exercises to be effective. I will describe below how I work with the internalization of contact.

I ask the client to feel their body (somatic correlate of the sense of self) and to feel the space between them and me while maintaining eye contact with me (somatic correlate of connection and contact), like what I have described above, thus connecting to their body and to me. After a minute or two, or when I feel that it is appropriate to go to the next phase, I ask them to close their eyes and imagine that I am getting closer to them (as close as they are comfortable) until they experience my energetic presence and then I ask them to stay with this sensation and feeling for about a minute or until I sense that they feel their contact with me in their body. I believe that this last step is the somatic correlate of internalization. Thus, through this energetic and somatic exercise, the client first connects with themself and then connects to the therapist and finally internalizes the contact. After this exercise, the clients typically feel much calmer and feel a deeper connection with me and their bodies. My clients have reported that after this exercise they can self-soothe in between sessions or when they feel overwhelmed emotionally. I must emphasize that connecting with the self and to the good object and internalizing it is a lengthy process. This exercise may simply speed up the process by letting the clients feel the connection with themselves and with the good object, and to form a psychological imprint of these processes, through formation of new neural networks (initially weak) formed during their experience in this exercise. Future therapeutic work is then built upon strengthening these newly formed neural networks.

Case of Susan

Susan was a woman in her late 20s who came to see me due to severe anxiety. Her anxiety was so intense that she froze at work and could not function well. She was most anxious at work where she felt lonely and without support. She felt that her superiors were constantly watching her performance and might fire her if they deemed that she was not performing well at work. Her anxiety was debilitating. Even when not at work, the chatterbox in her head was continually activated making her life exceedingly difficult. Susan’s early life was not devoid of trauma. Her father was a disciplinarian who would frequently discipline her and her siblings. She recalled on one occasion, as a young child, when she fell and hurt herself, her father punished her instead of soothing her and tending to her pain. Susan’s mother was unavailable. She was a weak woman who was subservient to her husband and not very available to her children. Susan’s anxieties were of a persecutory and a depressive nature. She formed positive transference with me early in therapy. I took advantage of the positive transference to work with her using the techniques described above. Please note that for a lasting change and healing transference and resistance must be analyzed and processed. I judiciously delayed this phase of her treatment until she felt better and was out of the crisis. I asked Susan to stay with her body and then to connect with me as I discussed in the technique discussed above. She felt better very quickly. She said that she felt that she had support and was not lonely anymore. I mentioned to her that when she was at work and felt very anxious, she could close her eyes and imagine that I was 4 or 5 feet away from her. She would then need to feel her body and feel the space between herself and what she

imagined to be me. She felt relief when she did this exercise by herself. Once she felt better, we started working together on her transference and her early traumas.

I now turn the reader's attention to existential anxiety. A child feels safe not just when he experiences his mother's (or significant caretaker's) unconditional love, but when his mother receives his love and is moved by it. The existential anxiety can be alleviated when one feels that there is someone to love without any expectations. My former therapist, Robert Hilton (personal communication, August 2019) quoted one of his clients who said he had read that the therapist's job was to teach the client how to love him and to let him. Bob also mentioned that he had experienced the truth of this observation in his own therapy. When he was facing his own existential anxiety, it was the capacity of his therapist to receive his love that grounded him in his body and presence. This love is experienced as a spontaneous body aliveness that had been previously crushed. (R. Hilton, personal communication, August 2019).

At the time when Bob Hilton first mentioned this to me, I was not sure if I fully understood him, until I faced such anxiety and discussed it in one of our therapy sessions. He reiterated to me again that when we face such anxiety, we feel lonely, and we need to feel that there is someone who receives us and allows us to love them and that they do not want anything from us. For me and in my therapy with Bob, he was such a person who allowed me to love him without, of course, any expectations. This feeling of being allowed to love him alleviated my anxiety, and I did not feel that I had to face my issues alone and I felt that I had support.

After the passing of Dr. Michael Sieck, my psychology professor, and a bioenergetic therapist, one of his trainees and students wrote this about him "A week ago today a lovely being left this earth. The way that he taught me to love and allowed me to love him in return has transformed my life. While his spirit is now off to new adventures, I will spend the rest of my life actively knowing what it is to love him."

This form of connection has also been discussed, to some degree, in attachment literature. Bowlby (1983) hypothesized that the human infant is born with a brain that demands safety via an instinctive attachment and bond to the mother. The child is distressed when the mother is absent and this attachment behavior also causes the two of them to seek each other when the child is distressed, frightened, or in pain. John Bowlby (1988) writes:

> Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving … Nevertheless for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. (p. 27)

Bowlby (1988), more importantly for the subject of this paper, writes: "Whilst attachment behavior is at its most obvious in early childhood, it can be observed throughout the life cycle, especially in emergencies" (p. 27). Bowlby (1988) argues that when a person of any age feels secure, he is likely to venture away and explore the surroundings. But when he is not well, sick, scared, anxious, or simply exhausted, he is likely to seek the proximity of an attachment figure. The role of the therapist, in many ways, is similar to an attachment object. This role is to provide a secure base from which the client can venture out and explore and when in distress can return

to. The secure base provided by the therapist will, in many cases, be internalized by the client, and this is also a goal of therapy. However, under severe stress, the client needs to actively come back to it for a sense of safety and security.

The need for the therapist's love for the client, if the therapy is going to be successful, has been discussed in the literature in detail. However, the client's love for the therapist is not very much discussed in the literature, except in the context of transference. Of course, when the client initially musters enough courage and expresses his love for the therapist, a question arises, namely, whether the therapist can receive his love (having dealt with his own narcissistic needs) and remain a source of support for the client. Is the therapist able to withstand the client's subsequent attacks with the intent to destroy the love object (the therapist)? These questions have also been discussed in the literature (Hilton, 2007) in detail.

Bob Hilton's statement to me (personal communication, August 2019) that under stress one needs a person who allows him to love them without any expectation, however, goes deeper than what is offered by the rich literature in attachment theory. In the next section, I will discuss the deeper meaning of this statement and assertion.

During the final year of my therapy with Bob Hilton and before his retirement in early 2019, he mentioned that he wanted his clients to take in and internalize the connection with him and for him to receive the clients. We spent several sessions being quiet and for me to regulate my limbic system with Bob's when my nervous system was somewhat dysregulated. The feeling at the end of these sessions was one of being grounded with a sense of well-being as well as a sense of peacefulness. It was as if something new was being created (or co-created) within the intersubjective space, to paraphrase Daniel Stern (Stern, 2004). Bob and I also discussed this co-creation and the limbic transformation that was happening and how it felt to both of us. This, I later learned, was not unprecedented. Toward the end of his analysis with Winnicott, Guntrip (1994, p. 20) tells him: "I feel now I've got my central self in touch with you. You've understood and accepted, and no need to talk now. I can relax and be quiet." Later Guntrip (1994, p. 21) says to Winnicott: "Now in silence with you I find my faith in the indestructibility of my internal good objects and can relax and feel safe." Kohut (1971) discussed this form of love and contact as the idealization of the therapist which he believed must be allowed and was favorable for a positive therapeutic outcome. Kohut (1971) writes: "... during late phases of treatment when a renewed idealization of the analyst has taken the place of the mirror transference, it provides the opportunity for a therapeutic transformation of an idealized parental imago into internalized ideals" (p. 141).

Let us now consider the treatment of existential anxiety from a neuroscience perspective. The limbic brain, the seat of emotions, emerged in the first mammals about 200 million years ago and the emergence of emotions reaches back to about 100 million years ago. The small mammals that first emerged needed and depended on each other for survival and this mutual need and dependence were regulated by the limbic system through feelings and emotions. It is understood that the development of the limbic system in humans starts prenatally.

Feelings and emotions in homo-sapiens have a deeper meaning. They allow two humans to receive the contents of each other's minds and are the transmitters of love. The limbic brain

has the specialized capacity to detect and analyze the internal state of other mammals. “Emotionality is the sense organ of limbic creatures” (Lewis, Amini, & Lannon, 2000, p. 62).

It is known (Lewis, Amini, & Lannon, 2000) that mammals can detect the internal emotional states of one another and can adjust their physiological state to match the other’s physiological state. This detection of each other’s physiological states is done via limbic communication which is especially prevalent in homo sapiens. Limbic communication has three constituent components.

The first component of limbic communication, upon which the other two components are predicated is limbic resonance. We all transmit information about our inner world through our limbic attractors. An attractor network is a type of recurrent (with feedback) dynamical network composed of interconnected nodes (neurons), that evolves toward a stable and persistent pattern over time. These limbic attractors betray one’s inner state through behavior, facial tones, and emotional and postural states. Limbic resonance is formed If one quiets down his internal neocortical chatter and receives the internal state of the other. As the limbic resonance becomes stronger the receiver can see the inside of the other’s personal world and feel what it is like to live there (Lewis, Amini, & Lannon, 2000). The authors write “Within the effulgence of their new brain, mammals developed a capacity we call limbic resonance - a symphony of mutual exchange and internal adaptation whereby two mammals become attuned to each other’s inner states” (Lewis, Amini, & Lannon, 2000, p. 63). Limbic resonance is learned from an early age when a mother attunes to her baby via deep eye contact. Lewis, Amini, & Lannon, (2000) write “Eye contact, although it occurs over a gap of yards, is not a metaphor. When we meet the gaze of another, two nervous systems achieve a palpable and intimate apposition” (p. 63). As therapists, we can establish limbic resonance when we quiet down our thoughts and our neocortical activities and establish eye contact with the client and attempt to perceive them. Knowing the other and perceiving the other comes from our own self-knowing and self-perception. We need to tune in to ourselves before we can tune in to the other. Thus, the first requirement for the therapist is to know thyself!

The second component of limbic communication is limbic regulation. Human physiology has evolved so that limbic systems can have a harmonizing effect on each other. This harmonizing effect is mediated through relationships which are at the core of our limbic neural architecture, and which can regulate the activity of our limbic (emotional brain) system (Lewis, Amini, & Lannon, 2000). If we and our clients are to navigate through a healing path, we must allow the limbic regulation to guide us through the process. When we see clients in our offices who regulate their limbic systems through ours, we and they notice that they become calmer, more able to face their day-to-day activities, act stronger, and carry a sense of well-being and safety. We can have a regulating effect on the limbic system of our clients when we allow them to form limbic resonance with us while we tune in to ourselves and while we stay in contact with them.

Lewis, Amini, & Lannon (2000) write “In a relationship, one mind revises another; one heart changes its partner. This astounding legacy of our combined status as mammals and neural beings is limbic revision: There is power to remodel the emotional parts of the people we love, as our attractors activate certain limbic pathways and the brain’s inexorable memory mechanism reinforces them” (p. 144). And this brings us to the third component of limbic communication

which is the limbic revision. Our brains and more specifically our limbic systems wire through experience. New neural networks form as the brain conforms to novel situations. Lewis, Amini, & Lannon (2000) write “When a limbic connection has established a neural pattern, it takes a limbic connection to revise it” (p. 177). Robert Hilton (Personal communication, 2019) often quotes Guntrip (1994) “If it is bad human relationships that make people emotionally ill, it can only be a good human relationship that can make them well again” (p. 401). In other words, the limbic attractors can change in relationships. And in therapy, this change occurs when the new attractors (neural networks that have reached a degree of stability that respond in a given way to stimuli), in the limbic system of the client, form such that they become closer and more like those of the therapist. This process is iterative and with every iteration, the newly formed neural pathways of the client which are initially weak become stronger, form the new limbic attractors, and move closer to those of the therapist. The therapist has a set of indispensable tools which are his strong sense of self, self-knowing, and self-relatedness. The strong sense of self, self-knowing, and self-relatedness of the therapist can result in limbic revision within the client. However, with limbic revision comes a great responsibility which is that we must leave a person better than when we found them. It is of course true in that it is the person that we love, who can be the object with whom we can regulate our limbic system. Lewis, Amini, & Lannon (2000) write “Who we are and who we can become depends, in part, on whom we love” (p. 144). Thus, it is the limbic regulation that has a stabilizing effect on our dysregulated nervous system. However, limbic regulation can occur primarily with someone that we trust, someone with whom we feel safe, someone that we love. However, this special someone must be able to receive our love without expectations and must be someone who has done the work themself. A therapist cannot do this with his client unless he has experienced this in his own therapy (R. Hilton, Private communication, July 10, 2019).

A technique

This technique demonstrates one iteration of limbic regulation and revision, which are, in my opinion, an essential part of treating existential anxiety. In my experience, the application of this technique can be somewhat taxing on the therapist. I use this technique sporadically and rely more on the natural process of limbic regulation and revision which occurs within the therapeutic process. Similar to the technique described above, I ask the client to stay in contact with their body and stay in contact with me (Figure 2). Once they can master the contact with themselves and the contact with me, I ask the clients to keep their eyes open for about two seconds and stay in contact with me and then to close their eyes and stay in contact with themselves (awareness of their body) for two seconds. I ask them to repeat this process for a few minutes or until I feel the limbic regulation and revision have occurred (when a marked change in their emotional state has occurred which I can read through my limbic resonance with them). And of course, they should quiet their minds and avoid thinking during this process. I need to stay fully with my own sense of self and self-relatedness while I stay in resonant contact with them. I also must stay with, feel, and be aware of, within myself, what it is that needs to be regulated and revised in the client’s limbic system. However, due to their limbic resonance and interactions with us, the therapists, the clients have an imprint (a weak interconnection of neurons) of our neural networks in their limbic system and what this technique does is to strengthen their existing but weak neural patterns that resemble our neural patterns, as therapists, thus helping the limbic revision.

Case of Tommy

Tommy was a young man in his late 20s, who initially came to see me several years ago complaining of acute anxiety. He indicated that he was traumatized by his brother and his friends and that he felt alienated. Tommy's mother had been working full-time ever since his birth and his father was absent. Tommy did not have many friends and felt disconnected and lonely. He did not receive any mirroring as a child. Not having received any mirroring as a child left him with the desire to idealize his father and older brother to compensate for his healthy narcissistic needs. However, in both cases he was extremely disappointed and traumatized. His father ridiculed him on various occasions, and his brother and his friends were abusive to him. Tommy had so much shame and in sessions he would usually look down and could not make eye contact with me. His central ego was weak resulting in existential anxiety. Tommy quickly formed an idealizing self-object transference with me. But, on a couple of occasions, as his transference got stronger, he left the therapy, and would not come back for a year or so. He recently decided to return to therapy after a couple of years. I interpreted his absence from therapy as a fear of getting hurt or ridiculed due to his strong transference. This interpretation made sense to him, and I indicated that indeed he was idealizing me and was afraid that I would hurt and shame him, like others had done in the past. We also processed his mirroring self-object needs. Our efforts in therapy have been focused on his needs for safety and on his mirroring self-object needs. I felt that his mirroring needs must be met first before he could form an idealizing self-object transference. I have also used the technique mentioned above with Tommy which has been highly effective in creating a sense of safety for him within our therapeutic relationship.

Conclusion

In this paper, I discussed signal anxiety and showed, based on a simplified object relations theory, that it can be partitioned into persecutory, depressive, and existential. Based on this theory, attachment theory, and neuroscience, I also presented relational somatic therapeutic approaches for treating persecutory, depressive, and existential anxieties. Several case studies were presented to show the efficacy of the presented theory and techniques.

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BIOGRAPHY

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