Contemporary Psychodynamic Approaches to Treating Anxiety: Theory, Research, and Practice

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Psychodynamic theory is founded on the idea that human behavior is influenced by forces and experiences that lie outside of conscious awareness. Despite what we may or may not recognize about our lived experience, an essential connection exists between unconscious processes and everyday psychological functioning. By extension, psychodynamic theory presumes that unconscious conflicts are pathognomonic of anxiety disorders and anxiety symptoms generally. The term "psychodynamic" refers not only to that which occurs within one's mind but also what happens between people and within families, groups, and systems. A comprehensive psychodynamic treatment of anxiety attempts to take into account these multiple domains of experience and functioning (including biological and genetic considerations) and applies a specific therapeutic approach to working with patients based in part on clinical techniques first developed by Sigmund Freud more than 100 years ago.

In his earliest theory of anxiety, Freud (1895) considered it to be the result of a buildup of libido that, due to repression, is not discharged. He later reformulated his understanding based on his development of a structural model of psychic functioning. In this "signal theory," anxiety is regarded as a safeguard to protect the ego's functioning from threatening impulses generated internally by the id. Anxiety *signals* the press of a threatening (often sexual or aggressive) impulse, which in turn activates the ego's defense mechanisms in the service of rendering it unconscious through repression. Freud also argued that repression can be accomplished by the process of distortion, in which the dangerous impulse becomes disguised or transformed into a more readily acceptable idea, neutralizing the threat.

Whereas in the earlier theory Freud believed anxiety to be the result of repression itself, in the later theory, anxiety was thought to be the result of a conflict between id and superego, or internal, unacceptable wish and the standards and morals

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imputed onto the individual by society and his or her environment. In this structure, the ego (or self) is placed precariously between conflicting messages to both satisfy an internal urge (generated by the id) and also act in accordance with external expectations (represented psychically by the super ego). This theoretical position is easily understandable when we consider the many instances in which a wish or longing can be at odds with environmental conditions that discourage one from actualizing it. The well-known phrase "forbidden love" may come to mind. In fact, Freud believed anxiety to be so ubiquitous that he suggested it was an essential precondition for membership into civilized society.

Freud also outlined a framework of psychosexual development, each stage of which is linked to anxiety about a particular developmental conflict. Anxiety at the most mature level related to guilt feelings and fear of retribution from the father in the Oedipal phase, which Freud categorized under superego anxiety. Other sources of anxiety, from more to less mature, included castration anxiety, fear of loss of love, and fear of loss of the object itself (separation anxiety). Subsequent psychoanalytic thinkers elaborated on Freud's theory by postulating even earlier forms including persecutory anxiety and disintegration anxiety, frequently found in the psychoses. Despite the hierarchical organization of these developmental types clinical experience suggests that patients are susceptible to experiencing many different kinds of anxiety, and at times several kinds at once, depending on the nature of the disturbance and factors affecting the patient intrapsychically and interpersonally [19].

The model of psychological functioning postulated by Freud was essentially intrapsychic, giving primacy to the mind's functioning in relation to itself. Successive generations of psychoanalytic and psychodynamic thinkers have increasingly recognized the role of interpersonal, relational, familial, and group experiences in the development of psychological symptoms. Developments in attachment theory and infant research have broadened an interest in the role of early relational patterns with caregivers in clinical work with both children and adults [13, 15]. As such, postmodern influences have inspired clinicians to consider the role of intersubjectivity and the reciprocal influence of the personhood of the patient and therapist in the clinical encounter, including transference-countertransference dynamics. What has evolved over time is a heterogenous group of theories and approaches to treatment with historical roots in Freudian analysis. Given the breadth and diversity in the field, this chapter will focus primarily on recent psychodynamic approaches to anxiety that have empirical support and can be feasibly delivered within the context of the current managed care landscape and in community settings. We have also chosen this focus in order to highlight pragmatic approaches to common clinical presentations, in line with emerging trends in the psychotherapy literature regarding transdiagnostic conceptualizations and treatments of anxiety. These approaches require minimal advanced training and can be employed by both seasoned clinicians and therapists in training, making them widely disseminable. Although we do not cover long-term psychodynamic therapy or psychoanalysis proper (for which empirical evidence also exists), those approaches have their own merit and provide the foundation from which current approaches have been developed.

Clinical Vignette

Mr. X, a 30-year-old man with a history of anxiety and depression and previous diagnosis of generalized anxiety disorder, presented to treatment with a psychodynamic therapist in the context of becoming engaged to his girlfriend of several years. Whereas his anxiety had previously been effectively managed with once-weekly supportive psychotherapy and an SSRI, he found that he was having more and more difficulty managing his anxiety symptoms, which were beginning to interfere at work and in his relationship with his fiancé. He had also begun to rely on alcohol more heavily than in the past in order to quell his worry and help him sleep.

In initial therapy sessions, Mr. X wondered whether he should resume use of an antidepressant or try a benzodiazepine, out of concern that his struggles would derail his engagement and jeopardize his wedding. Instead, the therapist suggested he bring his anxiety into treatment, so that they may understand why it had emerged with such force at this time. In order to accomplish this task, the therapist suggested he verbalize his thoughts and feelings freely as they arose in sessions, with particular attention paid to the memories, fantasies, fears, and wishes that appeared alongside his symptoms. In response, the therapist would listen for and comment on any unarticulated connections between these experiences, in an effort to help find meaning in Mr. X's symptoms.

Although Mr. X had some insight into why he was anxious, he could not account for why his worries had become so debilitating. He loved his fiancé and was excited to spend his life with her, making the issue confusing. As initial sessions unfolded, he spoke about the sense of duty he felt toward giving her exactly the kind of wedding she wanted and also his worry about something going wrong on the big day. The therapist noticed that as Mr. X talked about his sense of duty to provide "the perfect wedding," he displayed noticeable contempt and anger. The therapist shared this impression with Mr. X, who quickly retorted, "Well she can be quiet demanding. In fact it's downright infuriating!" In subsequent sessions, Mr. X spoke about his experience of feeling pressured by his fiancé to live up to impossible expectations, but unable to speak about his anger.

As Mr. X developed a capacity to speak about the range of feelings he had toward his fiancé, his anxiety about the wedding itself began to diminish. However, he still struggled to share his anger with his fiancé and remained anxious about the damaging effect he imagined his negative emotions would have on their relationship. As he associated to his experiences, Mr. X reflected on his memory of his parent's marriage when he was a child. He shared that his mother appeared to him heavily dependent on his father for attention and care. His father, however, was avoidant and unavailable, and his mother was loath to make her desires known to him, becoming instead conspicuously withdrawn and sullen. This dynamic led to a tense home where feelings often went unspoken. Mr. X often found himself attempting to cheer his mother up, inventing various ways to please her and later stewing angrily at the amount of time he felt obligated to care for her.

These memories led to further elaborations and a more thorough understanding of Mr. X's anxiety. In his relationship to his fiancé, he found himself in a similar position to his mother: wanting care and connection but uncertain about how to make his

desires known, as he expected them to be painfully rejected. He also found himself repeating aspects of his own childhood relationship with his mother, as he attempted to accommodate his fiancé's needs and give her exactly what he thought she wanted while feeling frustrated and angered by the effort he put into pleasing her.

This dynamic appeared to be repeated within the therapeutic relationship, particularly in moments when Mr. X seemed eager to please his therapist by offering "exciting" or "interesting" associations, and then seeming sullen and irritated when his emotional intensity wasn't matched. Over time and with his therapist's supportive encouragement, Mr. X began to speak more freely about the way he longed for his therapist's care and how he was reluctant to disclose these feelings out of a fear of being met with rejection or lack of interest. The recreation of these dynamics in the therapeutic relationship provided Mr. X's therapist with an experience-near understanding of his patient's position within his childhood family. In turn they became able to work through a problematic relational paradigm in the here-and-now while experimenting with new ways of being in a close relationship that included risking and sharing his desires and feelings. This therapeutic process gradually allowed Mr. X to be more aware of the immediate and historical context for his anxiety and equip himself with a more flexible and adaptive manner of managing his anxiety with his wife-to-be.

Evidence Base for Psychodynamic Treatment of Anxiety

Historically, the research literature has appeared to suggest psychodynamic therapy (PDT) to be less effective than cognitive behavioral therapy (CBT) and other therapies for multiple classes of disorders, including anxiety disorders. At the same time, a compelling body of evidence supports the notion that all *bone fide* therapies – that is, treatments consisting of active therapeutic elements derived from a coherent theory of psychopathology – are uniformly effective [41]. Based on substantial evidence on the importance of therapist and patient factors on outcome [2, 7, 24], the recommendations set forth by APA's Presidential Task Force on Evidence-Based Practice [1] support the notion that an effective approach rests not only on specific techniques but also on a variety of factors known to have a positive impact on all therapies, most notably the therapeutic alliance. Today the best evidence suggests that PDT therapists practicing in a flexible, responsive manner to patient needs as they arise in treatment – and not simply in fidelity to rigid, historical, theoretical understandings – have the best chance of effecting positive change in their patients.

Unlike CBT, PDT practitioners have typically eschewed disorder-specific treatments in favor of a more universal, or "generic," approach. Rather than develop individualized treatment manuals for particular manifestations of psychological distress, a PDT framework remains more or less consistent and applies a similar set of techniques across a wide range of disorders. This predilection is one reason why in the past PDT has appeared not to fare particularly well in comparison with other treatments for anxiety and other disorders. Randomized control trials (RCTs) examining the efficacy of PDT for specific mental disorders in relation to other therapies

often use different, poorly operationalized, conceptions and methods of PDT interchangeably, leading many PDT treatments to be deemed only "possibly efficacious" when judged by the criteria of empirically supported treatments (ESTs) [25].

In terms of comparison trials, although PDT has been shown to be less efficacious than CBT in studies in which a disorder-specific cognitive behavioral manual was used [12], two recent and well-conducted meta-analyses challenge the notion that PDT is inferior. The first examined the controlled effects of PDT for anxiety disorders among 14 RCTs [21] and found PDT to be significantly more effective than control conditions. (The authors reported an effect size of g = 0.64, with *g* representing a more conservative estimate of effect size for small samples than Cohen's *d*.). These results were detected among primary and secondary outcome measures, and they were maintained at follow-up at 1 year (g = −0.11) and after a year (g = −0.26). The second examined 39 RCTs across a range of disorders [28] and found PDT to be efficacious for social anxiety disorder (SAD) and possibly efficacious for generalized anxiety disorder (GAD). Further, the combination of PDT with psychopharmacology was also deemed efficacious for panic disorder (PD) and SAD. Importantly, this meta-analysis included both manual-guided psychodynamic treatments, as well as short-term, long-term, and group formats of PDT, all of which included clear descriptions of the theoretical background and technical recommendations such as indications, interventions, and timing.

Additionally, a recent Cochrane network meta-analysis [37] compared the efficacy of eight different forms of psychotherapy for panic disorder. Despite the generally low quality of evidence for outcomes evidenced across the entire network, and inclusion of only two studies examining PDT for panic disorder, PDT demonstrated higher tolerability among short-term treatments than CBT (odds ratio [OR] 0.52, 95% confidence interval [CI] 0.15–1.8) and comparably high rates of remission at 6 month follow-up. The authors concluded that although PDT appears to be the best tolerated of the psychotherapies, further research needs to be conducted in order to bolster the evidence and better explore the relative efficacy of PDT and CBT.

Naturalistic and quasi-experimental studies have also provided evidence for the benefits of PDT for anxiety disorders, with some mixed results. The reader is directed to Slavin-Mulford and Hilsenroth [38] for a thorough review of this research literature. Overall, PDT has been shown to have marginally smaller effects compared to cognitive, behavioral, and CBT treatments, although many of the studies comparing these modalities found large effects for both treatments (e.g., [23, 27]). PDT studies have consistently demonstrated large effects, and following PDT patients meet criteria for anxiety diagnoses at a reduced rate, have fewer symptoms of anxiety and co-occurring depression, and report lower levels of global distress [11, 32, 39]. In an updated review of outcome studies and meta-analyses of effectiveness studies of PDT for a range of major mental disorders, Fonagy [14] concluded that treatment approaches generated from PDT principles appeared to benefit patients presenting with symptoms related to SAD, GAD, and PD.

Taken together, PDT appears to be no better or worse than other active treatments for anxiety disorders, based on results at both the conclusion of treatment and at follow-up. Despite this evidence, the few studies examining specific mechanisms of

change in PDT have not yielded consistent results [8, 10, 40]. This inconsistency has led researchers to call for future trials of PDT for both specific anxiety disorders and examining the anxiety spectrum as a whole [38], as well as examining processes of change common among effective therapies and specific to PDTs [21].

A brief word should be said about how PDT appears to fare in comparison to psychopharmacological interventions for anxiety. Based on their review of the few existing studies comparing PDT to medication, Slavin-Mulford and Hilsenroth [38] assert PDT to be as efficacious as pharmacological interventions, and cite evidence that it may in fact enhance the effects of medication trials [42]. Impressively, they point to one well-designed study that showed PDT to be more efficacious for anxious patients with co-occurring personality pathology, based on primary anxiety outcome measures and improvements in social and occupational functioning [14]. A psychodynamic view of prescribing suggests that attending to the meaning of medications, and what they represent for both the patient and the prescriber, is an important aspect of the therapeutic engagement that has direct implications for the success of the intervention. More on this topic can be found elsewhere [33, 36].

Existing Psychodynamic Approaches to Anxiety

Psychodynamic theorists beginning with Freud have discussed unconscious conflicts and their defenses in relation to a wide range of anxiety disorders, but as mentioned, few manual-guided treatments exist. Two examples illustrate how PDT conceptualizes the etiology, maintenance, and treatment approach of anxiety symptoms. Panic-focused psychodynamic psychotherapy (PFPP; [9]) posits that panic attacks arise from unconscious conflicts related to dependency, attachment, and feelings of anger. In this conceptualization, panic potentially serves as a disguised means of expressing a need for care, an aggressive and coercive attempt to attract the attention of caregivers, or a form of self-punishment brought on by guilt around dependency strivings. Treatment consists of exploring and understanding the emotional significance of panic, delineating its meaning in relation to previous difficulties with caregivers, and working through these conflicts by recognizing how panic emerges across multiple, related settings. Leichsenring et al. [26] developed an integrative treatment for SAD that directs therapists to explore the affective aspects of shame and the unrealistic demands socially phobic patients make on themselves to perform in social situations. These techniques are utilized in combination with self-guided symptom exposure in the middle phase of treatment. Exposure is framed psychodynamically by explicitly relating it back to the therapeutic relationship and to underlying, repetitively experienced, relational themes.

More commonly, therapists practicing contemporary forms of PDT in clinical settings employ a collection of techniques from within a larger, and not always consistent, theoretical umbrella. Although there exists no definitive technical definition of PDT, Blagys and Hilsenroth [5] identified several key features of short-term psychodynamic psychotherapy (STPP), most notably (a) a focus on affect and the expression of emotion and (b) the identification of patterns in actions, thoughts, feelings, experiences, and relationships. These patterns are usefully conceptualized

and explored using the Core Conflictual Relationship Theme (CCRT) format, as developed by Luborsky [29]. The CCRT focuses on what a patient wants from relationships (the wish; W), the response he/she expects from others (response from other; RO), and the patient's subsequent affective and behavioral response (response of self; RS). With regard to anxiety symptoms, the CCRT provides a cogent method to draw out the relational struggles that cause distress, and à la Freud, the affective and intrapsychic conflicts that can result and produce symptoms of anxiety.

Another universally applicable PDT concept that is fruitfully applied to anxiety symptoms is Luborsky's [29] model of supportive-expressive (SE) therapy. This model represents a continuum of interventions thought to work synergistically in order to bring about symptomatic improvement, and can be variously employed based on a variety of patient factors. Expressive interventions, such as transference and defense interpretation, are intended to promote insight and self-understanding, which can help the patient tolerate the uncomfortable affects and fantasies that mobilize problematic defenses and produce anxiety. Conversely, supportive techniques are used to help enhance patient's adaptive capacities and most importantly can foster to the development of a secure therapeutic alliance. Enlisting the patient's collaboration in becoming curious about the meaning and developmental origin of his or her anxiety rests on the therapist's capacity to build of a "holding" environment, so that difficult affective and relational experiences can be faced and explored collaboratively. Given the aversive nature of anxiety, many people are initially more motivated to extinguish the experience (often through avoidance) rather that tolerate its presence, which is often required along the pathway to understanding and meaning-making. Luborsky [29] and Crits-Christoph et al. [11] developed a number of principles and therapeutic actions to foster the development of the alliance in PDT, including socializing the patient to the tasks of therapy. Luborsky [29] also usefully suggested that a greater number of supportive interventions may be needed for patients with greater psychopathology or when in times of crisis.

Psychodynamic Techniques with Empirical Support

At present, few studies have examined the impact of specific techniques in psychodynamic therapy for anxiety disorders. A recent study examining the use of interpretations in PFPP [22] found that panic-focused interpretations improved panic symptoms in the middle phase of treatment (B = 1.79 [95% CI: 0.61, 2.97], SE = 0.59, t = 3.04, p = 0.004, adjusted p = 0.016, sr = 0.37), while interpretations about conflicts that did not include a panic-focus did not (B = −0.47 [95 CI: −1.54, 0.60], SE = 0.54, t [59] = −0.88, p = 0.382, adjusted p = 0.437, sr = −0.09). In light of these findings, the authors argued for the importance of taking a symptom-focused approach in STPP for anxiety, although they could not confirm the presence of a causal relationship between the intensity of panic interpretations and symptom change. Within a naturalistic/effectiveness model of STPP for anxiety, Slavin-Mulford et al. [39] conducted one of the first studies to examine treatment fidelity, credibility, and satisfaction in an outpatient community population. Examining the relationship between the use of specific psychodynamic interventions (PI) in the

third session and reduction in anxiety symptoms at posttreatment ($r = .46$, $p = .04$; [39]), the authors identified several individual PI techniques that were found to be meaningfully related to outcome. A follow-up study using the same sample of anxiety disorder patients [34] found a significant relationship between psychodynamic technique and posttreatment change in anxiety symptoms at the ninth session ($r = .49$, $p = .03$) and at mean levels of psychodynamic technique across both third and ninth sessions ($r = .53$, $p = .02$). Based on these findings, the authors suggested that there is a positive relationship between techniques intended to increase understanding of cyclical relational-affective patterns early in treatment and subsequent improvement in anxiety symptoms.

A second follow-up study [35] extended this work by applying it to a transdiagnostic sample of patients, in order to clarify whether the same, or different, PI interventions would be found effective for patients with subclinical levels of anxiety as they were with patients suffering from severe anxiety disorders. Given the implications for emerging trends in the psychotherapy literature regarding transdiagnostic approaches to psychological problems, this study will be discussed below.

Providing Alternate Understandings of Symptoms

In Luborsky's supportive-expressive continuum, providing an alternative understanding of anxiety symptoms represents an expressive intervention aimed at deepening patient's exploration of his or her anxiety and gaining an appreciation for its meaning that may not be readily apparent. Another way to describe this intervention is "interpretation," which throughout the history of PDT has been a cornerstone of its approach. By maintaining a consistent focus on deepening patients' exploration of their internal experience and attending carefully to the treatment frame, therapists can learn to recognize the relational and emotional circumstances in which anxiety arises. Oftentimes, this may occur in moments of therapeutic rupture or even expectable separation, such as weekends or the therapist taking a vacation. Therapists can then use the knowledge gained through their own experience with the patient's anxiety in order to generalize to other relationships, including their earliest experiences with caregivers, thereby gaining a subjective appreciation for the etiology and function of these symptoms.

One example of how the CCRT is used in treatment for anxiety disorders can be found in Leichsenring et al.'s SE-based treatment manual for social phobia. In this protocol, the therapist is instructed to utilize the CCRT as a way to provide an alternative understanding of symptoms at the outset of therapy and as they recur throughout the course of treatment. Based on a formulation by Gabbard [18], a CCRT for a patient with SAD may be described as wishing to be affirmed by others (W), expecting that others will humiliate him or her (RO), and feeling ashamed and afraid of being together with others, therefore deciding to avoid exposing him- or herself (RS = symptoms of social phobia). During the termination phase, the CCRT can also be used to address the resurgence of phobic symptoms in anticipation of the loss of the therapist and the patient's fear that the wish to be cared for and accepted will not be fulfilled.

Recalling the clinical vignette presented in the beginning of this chapter, a CCRT for a patient with GAD might be articulated as follows:

> *You want others to take care of you (W), but you are afraid that they'll fail you, either because they aren't emotionally capable of being there or are preoccupied with something else, such as preparing for an important event like a wedding (RO). This leads you to withdraw, to feel lonely and sad, and to worry a great deal about whether you are able to meet your obligations. You become angry or critical of others' inadequacies and may even become critical of yourself (RS).*

The process of outlining the CCRT aims to help the patient achieve insight into the underlying meaning of their anxiety symptoms and to begin to develop more adaptive means of coping with the preoccupying symptoms of worry and anxious distress.

Focus on Affect and the Expression of Emotions

As described above, gaining a new understanding of anxiety symptoms as they relate to the patient's self and relationships entails an affective component, namely, by identifying and exploring the warded off emotional experiences that the patient finds too painful or overwhelming to bear. The defensive function of worrying is an animating principle of Affect Phobia Therapy (APT; [31]), which views inhibitory emotional responses such as anxiety, guilt, and shame as obstructing the experience of painful but genuine emotions. Using the triangle of conflict and triangle of person models developed by Malan [30], APT helps patients develop new understandings of their symptoms in relation to present and past relational-affective events.

As previously described, Leichsenring et al.'s [26] manual-guided treatment for SAD incorporates self-guided symptom exposure in the middle of treatment. Although customarily exposure activities have been more associated with CBT than PDT [6], it has been suggested that exposure and exploration of uncomfortable feelings are active in PDT, though the context is different from that provided in a traditional CB format. Helping the patient become aware and tolerant of their disavowed emotions in the here-and-now with the therapist has been conceptualized in terms of lowering experiential avoidance, which is thought to be a core process in the development and maintenance of anxiety [20].

Thus, whereas Freud suggested that treatment of anxiety should consist of bringing the threat into consciousness in order to help the patient understand that it no longer represents a present danger, current dynamic approaches emphasize the affective and relational aspects of symptoms with the intention of reducing related emotions such as shame, grief, rage, and humiliation. Emotional insight is achieved in part by the therapists' making connections between past and current relational-affective events, including those that arise within the therapeutic relationship. The emphasis on developing more adaptive patterns of interpersonal relatedness is a feature of most contemporary, brief forms of PDT, while longer forms including psychoanalysis may require greater patient autonomy in learning from and applying insights gained in therapy to real-world experience.

Anxiety and Reflective Function

The ability to learn, make use of new insights, and improve relationships requires a range of cognitive, affective, and interpersonal reflective capacities. Fonagy et al. [17] have proposed the concept of *mentalizing*, operationally defined as *reflective function*, to describe the process by which an individual makes sense of behavior (their own and others') as meaningfully predicated on underlying mental states such as thoughts, feelings, wishes, or intentions. This theory, grounded in psychodynamic theory, attachment research, and cognitive-affective neuroscience, proposes that the capacity to mentalize is developed within the context of our earliest attachment relationships. Given average, expectable conditions, the capacity to mentalize emerges over the course of development. Conversely, early childhood trauma or disruption in our attachment relationships may disrupt the development of the mentalizing capacity, leaving one vulnerable to further difficulties later in life.

Regardless of one's developmental trajectory and baseline ability to mentalize, the capacity is not static. Mentalizing theory asserts that activation of the attachment system derails the ability to reflect, leaving the individual to revert to mental operations that antedate the development of the mentalizing capacity [3]. Thus, the capacity is fluid and inhibited by anxiety aroused in close interpersonal relationships. While interpersonal disruptions and subsequent attachment anxiety are more prevalent in some groups than others, individuals with Borderline Personality Disorder being a prime example, such ruptures are ubiquitous to the human experience [4].

Mentalization-informed approaches to treatment are uniquely interested in anxiety aroused in interpersonal contexts. Because anxiety diminishes one's capacity to flexibly reflect, learn, and develop new insights, it must be intentionally addressed in treatment to restore robust mentalizing and maximize the potential for therapeutic gain. In mentalization-informed approaches, interventions made by the therapist are offered based on a careful assessment of the level of anxious arousal in the patient at a given moment. The more anxious the patient, the less likely they will be able to make use of interventions that would require robust mentalizing. For example, a therapist may be misguided in offering an expressive, interpretive intervention in these moments. Instead, supportive interventions may restore mentalizing capacities by reestablishing an empathic working alliance (akin to a secure base in attachment language), from which arousal might be diminished and the ability to achieve insight restored.

Future Directions: Unified and Transdiagnostic Approaches to Anxiety Symptoms

There is currently a growing trend toward transdiagnostic treatments based on the still relatively unsatisfactory outcome and remission rates for PDT for anxiety disorders. One promising example is the recently developed *Unified Psychodynamic Protocol for Anxiety Disorders* (UPP-ANXIETY) [25]. UPP-ANXIETY integrates empirically supported psychodynamic treatment mechanisms, including many of

those mentioned in this chapter, across a wide range of anxiety and related disorders. In line with the unified, transdiagnostic approach, Pitman et al. [35] recently conducted the first study to systematically investigate whether anxiety symptoms respond to PDT techniques regardless of diagnosis, if the symptoms are at clinical or subclinical levels, or if they occurred in the presence of personality disorder pathology. The authors found significant decreases in anxiety symptoms across no anxiety disorder ($p = 0.004$) and total (anxiety disorder and no anxiety disorder) ($p = 0.0001$) samples, with improvements representing small to medium effects ($d = 0.48$ and 0.56, respectively). Results also showed several PDT techniques to be meaningfully related to anxiety reduction at outcome for the total sample, including (1) a focus on exploration of uncomfortable feelings ($r = 0.25$, $p = 0.03$); (2) linking current feelings and perceptions to experiences of the past ($r = 0.24$, $p = 0.04$); (3) focusing attention on similarities among the patient's relationships repeated over time, settings, or people ($r = 0.24$, $p = 0.04$); (4) identifying recurrent patterns in actions, feelings, or experiences ($r = 0.26$, $p = 0.02$); and (5) focusing on wishes, dreams, and early childhood memories ($r = 0.25$, $p = 0.03$). One technique, providing alternative understanding not previously recognized by the patient (i.e., interpretation), was meaningfully related to outcome for both the total sample and sample with no anxiety disorder (anxiety disorder sample, $r = 0.58$, $p = 0.01$; sample with no anxiety disorder, $r = 0.33$, $p = 0.02$; total sample, $r = 0.34$, $p = 0.003$). The authors suggested that these findings indicate there may be several PDT interventions that help with anxiety symptoms generally, and one intervention in particular that is helpful when anxiety is the specific focus of PDT.

Importantly, PDT techniques were found to be equally effective in reducing anxiety regardless of whether they presented with personality disorder pathology ($b = 0.414$, SE = 0.307, $t = 1.349$, $p = 0.185$). The fact that the PDT techniques identified as being effective for anxiety symptoms did not appear to be influenced or mitigated by Axis II diagnosis may provide further support for this type of broad, transdiagnostic, PDT approach. The authors suggested that practitioners utilizing PDT transdiagnostic protocols should feel confident in applying broad inclusion criteria when selecting eligible patients for this approach, provided that improvement on a targeted disorder or symptom (e.g., anxiety) is the primary goal of treatment.

In line with the Presidential Task Force on Evidence-Based Practice (2006), we believe it is crucial to consider the role of patient variables in affecting treatment outcome. Although presence of Axis II diagnosis alone did not moderate the relationship between PDT technique use and anxiety symptom improvement, this linear relationship was not maintained when the authors examined the presence of Axis I and II diagnoses together ($b = -0.548$, SE = 0.254, $t = -2.157$, p = 0.037). These findings suggest that practitioners applying a PDT transdiagnostic protocol should be aware that patients with co-occurring Axis I and II disorders may require a somewhat different configuration of PDT techniques in order for their anxiety symptoms to improve, in line with the flexibility advocated by Luborsky [29] and akin to the approach outlined in the UPP-ANXIETY [25] protocol.

Concluding Remarks

Psychodynamic therapists are fundamentally interested in the meaning and context for anxiety, actively attempting to foster curiosity in the patient about what the anxiety might signal. As such, anxiety might be thought of like the check engine light in a car. The light begs further investigation and careful assessment of the whole system. Finding a way to turn the light off without understanding the underlying problems it signals would be a partial solution at best. Rather than finding a way to quickly shut off the light, psychodynamic therapists are curious about the unseen disruptions that led to the signal in the first place. From this perspective, anxiety emerges when conflict reaches a fever pitch, often outside conscious awareness, eluding a coherent narrative in which it can be contextualized. The simmering conflict and related thoughts, feelings, and wishes that aren't expressed consciously then find their way to awareness in the form of anxious disturbance.

For therapists treating patients who report experiencing anxiety symptoms, current evidence suggests one effective, specific, approach to employ, especially early in treatment: the therapist should attempt to help the patient establish an understanding of his or her anxiety symptoms linked to the intrapsychic and interpersonal context in which symptoms occur. This effort includes helping the patient make connections between his or her current feelings and perceptions to past experiences, as well as across different times, settings, and relationships. Within this framework, the therapist can clarify for the patient the recurrent ways in which he or she internally experiences the actions, feelings, and occurrences that exacerbate anxiety symptoms.

A psychodynamic therapist accomplishes this task by focusing on helping the patient understand what it is he or she hopes to get out of their important relationships (i.e., the wish). From there, the therapist can help identify what the patient expects will be the response to that wish, and the characteristic way in which the patient in turn reacts to that perceived expectation. While these important clarifying issues should be ascertained early on, the therapist should continue to monitor these interpersonal patterns throughout the course of treatment, as they occur outside of therapy and also within the therapeutic relationship. In this manner, the therapist can help provide the patient with insight into the circumstances and processes that maintain his or her anxiety symptoms, give the space and perspective necessary to see how these patterns manifest in important relationships, and provide a safe and supportive environment in which to help the patient build up a tolerance for the difficult emotions that underlay the anxiety. Therapists at all levels of training and experience who utilize this model of treatment will likely find that providing this context for helping patients understand anxiety symptoms, and supportively engaging in the patient's relational world, is a beneficial and effective approach across many apparently different anxiety clinical presentations.

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