

New Views on the Psychodynamics of Phobias*

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After having differentiated phobias from pseudophobias, the author describes the three stages in the psychodynamics of this psychoneurotic condition. A case is reported in detail and interpretations offered. The new hypothesis is advanced that the unconscious motivation and the defenses go beyond the individual protection of the patient. Psychotherapy is discussed.

PHOBIAS AND PSEUDOPHOBIAS

I hope I am permitted to begin this article with a personal note. In my youth I knew a leader whom I greatly respected and admired, and who suffered from phobias. The whole town knew that he was afraid of animals, especially of dogs. It was actually the interest I had in him, the striking contrast between his unusually endowed personality and the ridiculous predicament in which his condition would at times put him that pointed out to me the mystery of mental illness and inspired me to become a psychiatrist. I plan to write elsewhere about the life of this man.¹ I wish to add also that because of my interest in this leader, the first studies I pursued in psychiatry were on phobias, and my very first patient—whom I treated when I was still a student in the department of psychiatry, where I was preparing the thesis required by European medical schools to graduate—was a person suffering from agoraphobia.

Although the subsequent course of my life led me to focus my research on other areas of psychiatry, the study of the phobic condition has always remained among my most vivid interests, and in the course of over thirty-five years I have accumulated quite a number of unusual cases.

I have seen many patients purely on a consultation basis, for the purpose of making a differential diagnosis between phobias and other conditions similar to phobias, which I shall call pseudophobias. I shall devote the first and shorter part of my presentation to these pseudophobias, which are interesting not merely from the point of diagnosis, but because they will help us to understand better what are the

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essential characteristics of real phobias and what is behind their manifest symptomatology. In the second and longer part of the paper, I shall speak about real phobias, and I shall illustrate my observations with a case report.

PSEUDOPHOBIAS

First of all, we must clarify a point which is not as evident as it seems. Not every fear or even abnormal fear is a phobia. I have seen, for instance, a large number of women who, from a few days to a few years after they had given birth to a baby, had developed the fear of hurting the child, maybe of killing him with a knife, or of throwing him out of the window. These women were generally brought to me to determine whether they were suffering from post-partum schizophrenic psychosis, or from phobias. The family also wanted to be informed as to whether the patient really constituted a danger for the child. These women are neither phobic, nor schizophrenic, unless, of course, they have other symptoms which are schizophrenic in nature. There is no definite avoidance of the child in these women or state of panic at the sight of the child, as it exists in phobic patients in the presence of the phobogenic object or situation. The fear is not acute, but remains in them almost constantly, as an obsession. As a matter of fact, these patients have an obsessive-compulsive psychoneurosis either precipitated or re-exacerbated by childbirth. Hidden behind the manifest symptomatology is the anxiety about the role of mother and motherhood, and an identification with the patient's mother, the child's grandmother. In these cases there is no danger to the child. I have not seen one case in which the child was hurt. Schizophrenic post-partum psychoses are very common, and may constitute some danger to the child, but they have a different symptomatology. A definite danger for the baby exists in post-partum depressions. The suicidal mother may include the baby or all her children in what she considers the suicidal resolution.

Pseudophobias occur frequently in schizophrenia, especially in relatively mild cases. I am not referring to definite fears which stem from paranoid delusions, like the fear of being poisoned, kidnapped, or ridiculed by a persecutor. I am referring to symptoms intermediary between phobias and delusions. For instance, a patient is reluctant to go to bed because she is afraid that during the night a man may come out of the closet and strangle her. The fear persists although she has checked and seen that nobody is in the closet. The hostility of the world, or the hostility of the persecutors, assumes the symbolic aspect of the man who comes out of the closet and will take advantage of her to kill her, or to abuse her sexually while she is sleeping. The irrationality of the fear is

often recognized, but not completely. A doubt remains that the fear may be justified. When the patient improves, the symptom loses the characteristic of the delusion and is replaced by a more typical phobia. Pseudophobias and phobias which occur in schizophrenic patients are as a rule less resistant, more fleeting in character than in typical psychoneurotic phobic patients, and generally have a more favorable prognosis as far as the symptom is concerned.

Even children who seem to be afraid to go to school are suffering from pseudophobias. I am happy that the term school phobia is much less used today. As Bowlby² has described, these children are not afraid of school, but of leaving mother, for whom they have a strong attachment, connected with undue anxiety. The fear of leaving mother is there, conscious, and is not replaced by symbolic symptoms.

In these pseudophobias that I have mentioned, and in many more which I could describe if time would permit, the manifest symptomatology is a concrete representation of the anxiety which rules the life of the patient, or of the drama which the patient is living consciously or unconsciously. However, even in the manifest symptomatology we can see the interpersonal character of the drama, for instance, the drama between the mother and the newborn child, between the woman and the male world of which she is afraid to the point of not being able to make romantic liaisons with any man. The child who does not want to go to school has an interpersonal problem with his relation with his mother, based on strong feelings of dependency and of uncertainty about such dependency.

PHOBIAS

The interpersonal drama is not so evident in the manifest symptomatology of real or typical phobias. First of all, what is the definition of phobia? A phobia is the perception of a specific and definite danger and the emotional reaction to danger, in situations where there is no objective danger. The patient experiences fear, for instance, when he crosses a bridge, when he sees a dog or a horse, and so forth. The patient realizes the irrationality of his feelings. Nevertheless, he cannot control his apprehensions and must avoid the phobogenic objects and situations.

Psychodynamics

The typical phobic condition is one of the few psychiatric syndromes which have been known since ancient times. The earliest description of a case is found in one of the books attributed to Hippocrates³ and probably written around 400 B.C. Although Stanley Hall⁴ and Pierre

Janet⁵ did accurate studies of this condition, a new era of deeper understanding started with Freud's work "Analysis of a Phobia in a Five-Year-Old Boy."⁶ Freud described how little Hans saw a horse fall and after that incident he developed the fear that a horse would fall down and would bite him.

Freud explained how horses had really nothing to do with the little boy's fears. Hans was experiencing sexual desire for his mother and had developed death wishes for his father, who was his rival. At the same time Hans developed fear of punishment for entertaining such wishes. According to Freud the phobia was implemented by displacement: the horse replaced the father, and the dreaded bite from the horse replaced the dreaded castration by the hands of the father.

Other psychodynamic schools have stressed that phobias are not necessarily based on repressed infantile sexual strivings and fear of punishment. The neo-Freudian schools of psychoanalysis connect the origin of phobias and other neurotic manifestations with disturbed relations during childhood and adolescence between the patient and the other members of the family, especially the parents. These disturbed relations would cause a state of anxiety, which later would manifest itself in a definite psychoneurotic symptomatology, and at times specifically in the form of phobias. Odier⁷ wrote that behind a phobogenic object hides a concept, an idea, a vague intuition. In a previous contribution⁸ I tried to investigate further Odier's concept, and I described how often the phobia is not just a displacement, as described by Freud, but also a concretization of a vague or intangible threat. I also pointed out that the phobic person retains a certain freedom of action in the context of his symptomatology. He believes he can escape the threat by avoiding the phobogenic objects. In other words, it will be up to him to avoid the situation which arouses fear. I also pointed out that one of the most important characteristics of phobias, contrary to what happens in the majority of delusions, is a "dis"-humanization of the source of fear. Frequently the phobogenic objects are bridges, cars, high buildings, etc. Animals (like horses, dogs, cats, insects) are often phobogenic objects, but humans are not. If some humans, like policemen or nuns, are experienced as phobogenic, it is by the virtue of a special role they play or of the uniforms they wear. In other cases the phobogenic object is an infective disease, and human beings are phobogenic not in themselves but insofar as they are innocent vehicles of the infection. Using Martin Buber's terminology,⁹ I pointed out that the phobic person who used to experience difficulty in interpersonal relations makes an attempt through his phobias to change the anxiety-provoking I-Thou relation into an I-It. I shall return to this point later.

Since I wrote the mentioned article, I have made additional observations which led me to reconsider and to reevaluate all the phobic patients whom I have seen in over three decades of psychiatric practice.

First Stage

An observation that I have made in many (but not all) cases which I studied psychodynamically is that these patients had been very sensitive and gifted in childhood. A rather large number of them had a happy early childhood, characterized by a basic optimistic attitude toward people in general, life, and the promise of the future. These patients, however, became badly disappointed later, at times as early as in late childhood, often in adolescence, and in rare instances in young adulthood.

Second Stage

From a "state of innocence" they brusquely passed to a second stage during which they considered themselves exposed to the mysterious unpredictability of life, to the sneak attack of danger, or to the errors and malevolence of others. At times it is an episode like the death of a parent which brings about the stage of general insecurity and dangerousness. At other times it is the discovery of a previously unsuspected horrendous or dishonorable aspect of life, or the realization that people whom the patient trusted very much are untrustworthy and even dangerous in a physical or moral sense. In only a few cases could I trace back the onset of this second stage of insecurity to the occurrence of typical Oedipal situations and fears of castration, as described by Freud.

In this second stage most patients are not phobic yet, but live in a state of not fully conscious anxiety. In my experience, they may become phobic much later, even from 5 to 20 years after the beginning of this second stage.

The earlier "state of innocence" which I have referred to may coexist with the state of instinctive dominance of the child described by Freud. Its loss, when the second stage starts, may be even more powerful in its effect than the primitive instinctual drives. This interpretation is not an application of Jean-Jacques Rousseau's idea that man is born innocent and society makes him bad. The "state of innocence" may also come from the external world; it may be an un verbalized assumption that the child makes in his early interchanges with his mother and with the acceptance of her great unconditional love. Having shaped the world according to the early image of love, derived from Mother or from both parents, he is badly disappointed later for a series of reasons which have

to do with other persons but vary in every case. We cannot exclude that a particular biological predisposition may make the patient particularly sensitive to this type of anxiety, experienced as a pervasive feeling that life is not safe but suffused with dangerousness. The danger is vague, diffused, invisible, intangible, and yet it seems immense and omnipresent because at a certain point in life it may become manifest as something unexpected and unpredictable.

The future patient now has to confront a dangerous universe. In a way which he cannot clearly verbalize, he experiences this danger as being of vast proportions, maybe connected with the whole of life or a large part of it. The life of everybody is always in a precarious state and uncertain equilibrium, threatened by diseases, earthquakes, motor accidents, fires, hurricanes, and so forth. But the patient who eventually becomes phobic is particularly vulnerable to what other human beings can do to his life. They may scold him, neglect him, ignore him, ridicule him, belittle him, disregard his rights, offend his human dignity, consider him not up to par, cheat him, rob him, enslave him, injure him, kill him, and so forth. They may transmit their evil, corrupt him, make him become dishonest, a cheater, or worse.

With similar feelings the patient could become a very detached person, overtly hostile, unable to love, but he does not become this way. He could become a paranoid schizophrenic, but he does not. Whether it is a constitutional predisposition or the love that he experienced in his early childhood which saved him from this fate, we do not know. He becomes phobic instead. He will become afraid of some specific objects and situations (bridges, squares, germs, dogs, horses, etc.), and he will continue to accept the rest of the world and to make overtures of friendship and love.

Third Stage

Generally it is either an important episode related in meaning to the dramatic child episode or an accumulation of life anxieties which brings about the third stage, characterized by typical phobias. In some cases the phobic condition starts or is exacerbated when new interpersonal situations develop which are threatening, for instance, when the patient gets married, has to go to live with or near the parents-in-law or with a step-parent, or has given birth to a baby. In these cases and many others, the human agents, like spouses, parents-in-law, babies, etc., are not consciously experienced as threats or only to a mild degree.

By becoming phobic the patient puts into effect several defensive maneuvers:

1. He reduces a diffuse or global anxiety to a definite concrete fear; for instance, he is now afraid only of crossing bridges.

2. Although it is true that the specific fear is always potentially present in him, he has now found a method to deal with it; for instance, he will avoid crossing bridges.

3. He has been able to change the source of fear from human beings to non-human phobogenic objects or to special environmental situations. The danger is also limited to his physical integrity, does not include the moral or psychological. For instance, the patient is not afraid of being corrupted, but of being infected with a contagious disease. As I said earlier in this presentation, the patient is able to change threatening I-Thou relations into an I-It situation.

It is on this third aspect of phobias that I wish to focus. First of all, we can say that contrary to what happens in pseudophobias, even in the manifest symptomatology of real phobias, the human relation which constitutes a threat or is threatened, is no longer visible.

Function of Phobogenic Object

Martin Buber is critical of the human being who relates to his fellow man as if he were a thing, an *It*, and not a person, a *Thou*. Buber is right, of course, when he refers to relations among normal persons. However, when the phobic displaces the source of danger from a person (or persons) to a thing, to a germ, or to an animal, not only does he do that to diminish his anxiety, but also to protect his fellow human beings, whom otherwise he would see in a way unfitting the human image. It would be horrendous for a human being to be so threatening; only an *It* could be that way. The phobic is the opposite of the slave-owner who reduces a human being to a tool. By resorting to his neurotic mechanism he is able to maintain a dialogic relationship with other persons, even those who caused his original anxiety.

The fact that quite often animals are selected as phobogenic objects is also of paramount significance. The phobic patient rejects the ancient dictum *Homo homini lupus* (Man is a wolf to man) and changes it into another: *Lupus homini lupus* ([only] a wolf is a wolf to man). The wolf here stands for any animal, or a non-human entity, which is inhuman to fellow men. Human beings are exonerated and the patient can continue to live in harmony with the human community. The animal becomes a real scapegoat. Freud actually hinted at this process when he wrote that by becoming afraid of horses little Hans could continue to love his father. He changed *Pater Johanni equus* (Father is a horse to Hans) into *Equus Johanni equus* ([only] a horse is a horse to Hans).

I believe that what I have so far illustrated will permit us to reconsider and possibly enlarge the motivational aspect of the psychiatric symptom. Although I am referring now exclusively to phobias, in

works now in preparation I make an attempt to explain that, with some important modifications, this particular enlargement of the motivational aspect of the symptom has to be found also in schizophrenia and in depression.

Imitating what Claude Bernard had done for general medicine, Freud showed that the psychiatric symptom has not only a regressive aspect, resulting from the damage or dysfunction caused by the illness, but also a restitutional aspect. Freud stressed that the symptom is also an attempt to repair, an effort to repress the unacceptable, a compensation, a way to achieve disguised or displaced goals. All this is true, but I think we can go even further in understanding the purposeful activity of the human psyche in health and in mental disease. The motivation goes beyond the protection of the patient himself. Often it includes an effort to maintain respect for fellow human beings and to retain a sense of their human dignity. By attributing the cause of his trouble to non-human sources, the patient protects the human image. Since he is human, he defends himself, too, but also the whole of humankind. This motivation, which transcends the interest of the patient himself, could even be called a spiritual motivation, or the spirituality of the human being as emerging even in mental illness. However, it is with a certain hesitation that in this environment I use these words, which are difficult to define, lead easily to misinterpretation, and seem more appropriate in philosophical and theological circles.

CASE REPORT

I shall speak now about a case which I intend to report in much greater detail in a future presentation. What I shall present today is only an excerpt of a long clinical history, but enough in my opinion to show how Freud's original discoveries and the observations and interpretations reported in this paper can blend in some cases.

The patient, a 53-year-old, Italian-born patient whom I shall call Guido, came to see me for an illness which had plagued him for over 20 years. He had resided in the United States for many years and had consulted many psychiatrists both in the United States and in Europe, but nobody had succeeded in helping him. The illness started when, in his late twenties, he was about to leave Italy to come to the United States. He then became afraid to touch anything or to be touched by any thing or human being, for fear of becoming infected. Guido told me that life had been torture, a living death to him for many years.

In the course of treatment he said that he could trace back the onset of the illness, the actual initial moment. He was in Sicily, in the village where he was born, and he went to a barber to have a haircut. He

noticed that the person who was sitting in the chair where he was supposed to sit next was an elderly and sickly man who appeared to Guido to be suffering from tuberculosis. The time came for Guido to sit on that chair, and he did, but soon developed the idea that he had been infected. From that day on he became afraid of touching any person living in the village, lest he become infected.

Later Guido told me that although the episode at the barber shop was the definite beginning of the illness, premonitory symptoms or quasi-symptoms had occurred a few days previously. He had left Milan, where he worked, and had gone to his native village in Sicily to say good-bye to his mother before coming to America, and also to make there final preparations for the emigration. While he was in his village, he heard that Bruno, a good friend of his, who also worked in Milan in the same firm where he did, was seriously and possibly critically ill. Guido heard the news from Bruno's wife who asked him please to accompany her to Milan to see her sick husband. Bruno and his wife were much older than Guido and had been friends of Guido's parents for many years. The patient interrupted his preparations for the trip to America, went to Milan with Bruno's wife, where they found Bruno seriously ill. What type of illness Bruno had, the patient has never been able to ascertain, and I doubt that it was an infective disease. Guido remembered that he was somehow hesitant and afraid to go to visit Bruno in the hospital. As a matter of fact, he remembered that the first time he left the hospital after visiting Bruno, he opened the revolving door with his foot. He did not want to touch it with his hand for fear of becoming infected. A few days later Bruno died, and after the funeral the patient returned to his village in Sicily.

A few days after the episode at the barber shop Guido's fear of becoming infected was no longer confined to people or things of his village, but spread to any person who would come from Milan or to any object manufactured in Milan. He could absolutely not touch any people or object coming from that city. When he came to the United States, he managed at first to do fairly well, and even got married and had three children; but the fear of touching any person or object coming from his village or from Milan persisted. With the passage of time his condition became much worse. Eventually he started to think that any person living in the United States could have touched somebody coming from Milan or from Sicily. Therefore he should avoid touching anybody.

I shall omit the detailed description of the symptomatology, which spread rapidly, paralyzed the activities of the patient, and caused anguish to an agonizing degree. Nevertheless, Guido was able to manage

an Italian-style café and to make a moderately comfortable living. In spite of his illness he has remained a friendly and warm person, very much loved by his three children. The wife, however, could not tolerate his illness and left him. The children remained with him.

During the course of treatment he told me that the first seven or ten years of his life were wonderful. He also said that the family atmosphere underwent a drastic change for the worse when his father died. The father was much older than the mother, and had been a very successful man, as a matter of fact, one of the most successful and respected persons in the village. Before his death, in old age, he had been blind for several years. After his death the economic condition changed completely. The mother, whom the patient described as a very loving and maternal person, did not know how to support the family. The patient himself at the age of 13 left the village to go to work in Milan, as many people used to do in his village, and would go to see his mother only at Christmas time.

Later in the treatment the patient told me that another very unusual thing had occurred before the father died. He was hesitant to tell me what it was all about; he had not revealed this information to any previous doctor. He remembers that one day, while his old and blind father was sick in bed, he, his mother, and Bruno, the friend whom I have already mentioned, were in the bedroom visiting the father. At a certain moment Guido turned his head from the direction of the father's bed to the place where mother was sitting and saw Bruno putting his hand over mother's thigh, over the high part of the thigh as to caress it or grab it. The mother allowed Bruno to do so, in front of the moribund and blind husband. Guido understood; that gesture was indicative that much more was going on between Bruno and his mother. He said nothing, did nothing, showed no emotional display. As soon as possible, that is, when he was 13 and felt no longer like a child, he left his village to go to work in Milan; and in Milan again, in the circle of people who were coming from his Sicilian village—friends and relatives—was Bruno, who also had gone to Milan to work. Guido saw Bruno regularly in Milan. Bruno was well liked by the circle of friends and relatives, and Guido tried to like him, too, although he was conscious of a certain reluctance to accept him entirely. Several years later, when Guido was in his late teens, Guido confronted Bruno. He told him, "Bruno, I saw what you did that day in front of my sick father. You did have an affair with my mother." Bruno became confused; did not deny the allegation, but became very anxious and told Guido, "Please, don't tell my wife. Promise that you will not tell my wife." Guido made that promise and kept it. As a matter of fact, when Bruno was very sick and

Guido accompanied Bruno's wife to Milan to see her dying husband, he had many opportunities to be alone with her, but he did not reveal anything.

DISCUSSION

Thus everything seemed normal until Bruno's sickness, Bruno's funeral, and Guido's return to his village. Then the illness exploded in a furious manner, and even years later gained in tragic intensity.

I must admit that I have not yet understood completely this interesting case, and that I am open to suggestions. Nevertheless, even what we know from this fragment of the clinical history that I have reported seems to me sufficient to permit the formulations of probable hypotheses.

Before I attempt an interpretation, I must state that as to the timing of the reported events Guido could give only approximate but not definite dates. We are in a position, however, to recognize in Guido's history the three stages of psychodynamic development that I described earlier in the paper.

We have a first period or stage of Guido's life, free of anxiety or of suffering, the first seven or ten years. Whether this period was really so serene as Guido described it, or has been idealized later by the patient, is hard to say. In this period the figures emerge of the respected and honored father, and of a loving mother. The picture changes and the second stage begins when the father becomes blind, moribund, and a cuckold. The crucial moment took place when Guido saw a sign of the last thing he expected to see, the proof of his mother's infidelity.

If we visualize the cultural milieu of a very conservative and somewhat backward Sicilian village, where matters of sex and honor are of paramount importance, we can understand how Guido reacted to the sight of Bruno's caressing mother's thigh. That gesture was more than a revelation; it was a cataclysm. It is fair to say that no child, no matter in what culture he was raised, would have liked to see such a compromising gesture in front of the dying and blind father; but in a Sicilian environment the episode acquired even more importance. That honest and trustworthy interpersonal world which Guido had envisioned in his mind all of a sudden threatened to collapse. But he did not permit it to collapse. Either because of psychological denial or for other reasons, Guido maintained his composure and silence, and, according to what he told us, continued to love dearly his mother and to maintain a certain restrained friendship for Bruno, too. It is very possible that the harmonious or relatively harmonious and loving environment of the first ten years helped him to build defenses. It is also important to note,

however, that as soon as he could, he left his mother and went to live in Milan. There he met Bruno again.

Guido made an apparently successful attempt to maintain normal relationships with the interpersonal world. At a conscious level he never blamed his mother, who was married to an old man; nor Bruno, to whom he also felt bound by friendship and loyalty. During this second psychodynamic stage, however, Guido is not completely well. He is a very insecure and fearful individual. Nevertheless he is able to live and work adequately.

With the illness and subsequent death of Bruno, the third stage starts and the phobic condition manifests itself with a violence which seems to equate the force of repression which must have been needed for many years. How is all this to be explained?

After Bruno's death there is no need any more for Guido to repress totally the pathogenic antecedents. Milan and the Sicilian village represent Bruno and Mother and become the focuses of an infection which may potentially spread to the whole world. Bruno and Mother remain innocent; the trouble is with the infection, which has allegedly originated in the two places where the culprits—of what must have seemed to Guido's once immature mind the greatest crime—live. Guido continues to exonerate or condone the two guilty ones, but, similar to what happens in the Greek tragedy of Oedipus Rex, a plague or potential plague is threatening. However, it can infect only him, because he is the only one who knows the crime and does nothing about it.

Of course, we can also consider to what extent Guido's Oedipal feelings are involved. Guido's rival was not his father, but Bruno; and whatever Oedipal hate Guido had must have been directed toward Bruno. It could be that he wished Bruno's death, and that when Bruno actually died, he felt guilty, or in an imaginary danger of being punished by the deceased Bruno through an infection which Bruno originated. I believe, however, that it would be a reductive approach to attempt to explain the whole picture from the point of view of sexual desire for the mother and fear of punishment from a paternal figure. I believe that other important factors to be taken into consideration in this case are the contrast between Guido's early childhood and his late childhood; the impact of the psychological cataclysm he underwent when he discovered mother's adultery, a discovery which could have engendered the collapse of his trusting attitude toward the world. The role he assumed was the opposite of vengeful Hamlet's. He made instead gigantic efforts to exonerate everybody, to continue to love everybody, and to attribute whatever disturbed him to a non-human source, a potential infection, incidentally transmitted by people. In my opinion, what is of

crucial importance in this case is not a sexual drama, but a moral drama, not the fear of castration, but the fear of what appears evil to the patient. The phobia gets hold of Guido and removes all the conflicts. Unfortunately it becomes so ingrained in his life to the point that his life is paralyzed. What must have been to him the gigantic shadow of evil was transformed into the shadow of a gigantic neurosis. The world is saved from a potentially spreading evil, but he, Guido, must contend with the potential spreading of an infection.

PSYCHOTHERAPY

I shall discuss briefly now psychotherapy, not in reference to the case I have described, but in general. The therapy of typical cases of phobic psychoneurosis constitutes a real challenge. In my experience any type of drug therapy is ineffectual.

I have found psychodynamic therapy useful, but only to a moderate degree. Since I started to understand the psychodynamics of phobias in the vaster framework that I have outlined, and I have succeeded in helping the patient to become conscious first, of his transition from the stage of innocence and happy childhood to the stage of generalized danger, second, of the unconscious effort made on his part to exonerate the human environment and to retain the capacity to love, and third, of the symbolic significance of certain late events in life, I have obtained considerable ameliorations of the disorder. However, even this larger psychodynamic understanding is not by itself sufficient to achieve a complete cure in a considerable number of cases.

This state of affairs is not difficult to understand. As I have explained in my discussion of the psychodynamics, the phobic symptom offers definite secondary gains, which are not really secondary but of paramount importance. It is difficult for a patient to relinquish a symptom which represses early pathogenetic traumas, eliminates a global climate of anxiety, and reduces it to a specific dangerous situation that in most cases he can avoid. In some cases, like Guido's case, there seems to be no reduction of anxiety because the phobogenic object is generalized. In these cases, too, however, the symptom permits the patient to retain warm interpersonal relations and the capacity to love.

In my experience, to be effective, psychodynamic therapy has to be supplemented by two auxiliary treatments. The first consists of the gradual exposure of the patient to the dreaded situation, in the beginning while he is accompanied by the therapist. It will be much easier for the patient to overcome the fear if the anxiety is diminished by the presence of the therapist, especially when the interpretations given have decreased the phobogenic power of the stimulus. Eventually the patient will be able to face the alleged dangerous situation by himself.

The second, and in my experience very useful auxiliary treatment, consists of altering or rearranging the whole life, family environment, and routine of the patient, so that the unconscious climate of anxiety of suspicion toward the interpersonal world decreases in intensity and there is less need to transform it into the specific fears.

I have found that the adoption of these three methods brings about recovery or at least amelioration in a large number of cases.

SUMMARY

It is important to differentiate phobias from pseudophobias. They differ not only in their manifest symptomatology but also in their underlying psychodynamics. According to the author's observations, in many cases of phobias a stage of relatively happy childhood is followed by a stage in which a generalized, intangible fear, related to other human beings, is perceived. This stage is often precipitated by a traumatic event. The third stage is ushered in by other events related to the original traumas or when the climate of anxiety increases. A phobic symptomatology emerges, which attempts, through defensive maneuvers, to limit and concretize the dangers and to maintain warm relations with fellow human beings.

The modalities of a combined form of psychotherapy are outlined.

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