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Anxiety in psychological perspective: pathology or project?

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Abstract

Based on our clinical experience as psychologists and the scientific literature, particularly on cognitive behavioral perspective, we propose a reflection on the concept of anxiety and its implications in psychological practice. Currently, anxiety is widely used in scientific language, in common language and in most different contexts, e.g., at school, at work or in the family. In psychological terms, the most commonly accepted definition of anxiety is an "emotional state". Will it be? Why so and why not? Is anxiety a pathological process or an element of life project? Is it a "cognitive error" or an "affective hesitation"? Would not it be the so-called "anxiety disorders" best understood in terms of "decision disorders"? To address these questions, two main points guide our analysis: 1) to emphasize psychological perspective of anxiety (anxiety as project) and distinguish it from the bio-physiological perspective; and 2) to differentiate normal anxiety from pathological anxiety. In a psychological perspective, three factors should be considered in order to understand anxiety: activity; future; and risk. Therefore, it is necessary to reverse the apparent phenomenon of "psychopathologyzation" of anxiety for a better psychological service to community.

Keywords: anxiety as emotional state; "de-psychopathology-zation" of anxiety; anxiety as project

Anxiety in psychological perspective: pathology or project?

Each period of time has its own paradigms (Kuhn, 1970), according to which the constructs and the subjects of investigation during that period of time are determined. Nowadays, the concept of anxiety is one of the "virtuous". A question arises: what is anxiety? What are the limits of anxiety in conceptual terms? From a psychological perspective, what is specific to this concept? What kind of process or activity is involved in anxiety? Considering the most commonly accepted definition of anxiety, as an *emotional state*, we would like to show that this definition is not operational as it does not allow discriminating normal anxiety from pathological anxiety. Given that anxiety has been mostly investigated within the cognitive-behavioral theory, we review this concept and its implications based on this theory. We present some alternative readings in order to highlight the psychological perspective.

Anxiety: what does it imply?

Four aspects seem to be always correlated with anxiety (Baptista, 2000; Baptista et al., 2005; Clark & Watson, 1991; Lang, 1979):

1. Anxiety is, or is associated with, an experience of discomfort, malaise for the person who experiences it.
2. Anxiety always involves physiological changes.
3. These physiological changes could prepare an individual to deal with a situation in order to solve it.
4. At the psychological level, anxiety is characterized by worry, tension, apprehension, uneasiness, and uncertainty.

Let us rethink each of these previous aspects. First, anxiety is not always considered a discomfort. For example, a person who experiences a new situation by traveling, always feels some degree of tension, apprehension or uncertainty. However, that does not necessary mean

discomfort or uneasiness for the subject. In fact, contrary to that, this new situation could be associated with pleasure and wellness, i.e., to positive emotions.

Second, although anxiety always involves some degree of physiological activation, which varies depending on the situation and the emotions presents, this physiological activation depends on the function of emotions. For example, the emotions enhancing the individual for action (motor) such as fear, anger or sexual desire imply a high degree of physiological activation. When the function of emotions is to communicate, the physiological activation is less present. This is the case in shame, which contributes in appeasement of conflicts by making people more lenient. This is also the case in anger, which function could be to intimidate, making the struggle futile. The physiological activation is therefore an important element of anxiety but certainly not the most specific.

The third aspect is directly related to the second one, i.e., the physical and physiological changes occurring in anxiety intend to prepare individuals to deal with the situation and to solve it. However, the possible reactions are not limited to fight, flee or freeze up (the "3 F"). The psychological aspect should not be minimized by this emphasis on physical aspects (physiological and motor).

Four and last aspect, the experience of internal anxiety is described by authors using various terms: lust, desire, restlessness, pre-occupation, apprehension, tension, uncertainty, doubt, fear, and threat. If we consider the meaning of these words, we can easily conclude that they all point to: *activity*, *future* and *risk*.

Indeed, *activity* could be explained by the fact that in individuals experiencing anxiety, their bodies and especially their minds are working too much. *Future* could be explained by the content of this activity which is intended for the future, either immediate or mediate. And *risk*, because the outcome of the situation may be favorable or fearful; the outcome may be closer to ones goals or not, and it could depend on the action taken or not.

Anxiety is experienced in order to allow individuals to anticipate the future. How can we avoid doing this? The human being is a temporal being who does not only experience the "here and now", but also the past and especially the future. This is why each individual is a psychological human being. Positive or negative expectations, "realistic" or "unrealistic" ones, high or low expectations, allow the individuals to build and operate accordingly. Lelord and André say that the thoughts of anxiety are focused on the risk of an uncertain adverse event: "What a pity if that happened!" (2003, p. 178).

Seligman compares anxiety with a "mental language" (2007, p. 73) that seeks what might be going wrong continually; it's like the alert light indicating that the oil level is too low in a car. If this alert is turned off, the individual could feel more distracted and more comfortable for a limited period of time, but this could cost a new engine. Despite the mechanic metaphor, it is useful for highlighting the communicative aspect of anxiety ("something is/is not well"), the dynamic aspect ("something must be done") and the temporal aspect ("making plans"). *Making plans* and *anticipating possibilities* imply a *future* dimension (immediate and mediate).

Reason versus heart or the levels of human activity

The dichotomy reason/heart started a long time ago in ordinary language. Blaise Pascal (1670, p. 251) wrote that "The heart has its reasons of which reason knows nothing". This philosophical adage has been updated by science, and seems to make perfect sense in the Psychology currently. The problem is that "reason" was identified with "cognitive activity", "heart" with "emotion" and emotion with "affective activity"; this results in a lot of misconceptions.

What is meant by "cognitive" and "affective"? Etymologically, "cognitive" comes from the Latin term «cognoscere» which means "to know and to analyze the data". However the analysis itself shows a reality that leads the individual to be indifferent. It is the affective

activity (valuation) that allows the individual to rank the elements and their relationships creating a reality which affects him. "Affection" derives from the Latin term «affacere» which means "what makes us act" («ad» = "toward" + «facere» = "to do"). It means that through the action of valuation, individual is affected by the reality and takes actions accordingly (Santos, 1993, 2005). Therefore, "act from what the heart dictates" (act "intuitively", act without thinking, "let yourself get carried away by your emotions") does not mean that cognitive processes (knowledge) are not involved. Similarly, "act from what the reason says" does not mean that the affective activity (valuation) is not implicated.

Reason considered as an abstract activity, made conscious and verbalized is not only a cognitive activity but also an affective one. "To think" and "to reason" have the same etymological origin from the Latin term «ratio», which means "to weigh". Thinking is "weighing values" (Santos & Silva, 1993). We also value (affective activity) reality in an abstract way (Santos, 1982, 1999, 2005). Fighting for your rights or dying for your country are actions involving abstract values (could be moral, religious, ethical or aesthetic values).

Our "reason" (conscious) does not know everything about ourselves (as in the philosophical adage of Pascal "The heart has its reasons of which reason knows nothing"). Language increases the awareness of ourselves, and therefore, allows individuals to take some distance from experience itself, thus contributing to release the dominance by emotions (due to the "reflective" ability, which is at an abstract or *intellective* level, and not "cognitive" as argued by cognitive and constructivist scientists). However, the conscious mind can "lock" the individual. In the individual experience, it can happen the dominance of emotion but also the dominance of thought. When dominated by its emotions, an individual continues "connected" to its immediate experience without taking appropriate distance in order to get prepared for new experiences (Guidano, 1994; 1995). That is why the benefit of emotional oriented therapies that focuse on thinking and verbalizing the experiences has been well

recognized. The dominance of thought or reflection leads individuals to minimize the scope of their immediate experience. So, excessive conceptualization is negative for new experiences as the new tones in life arise from immediate experience (Guidano, 1994; Jesuíno, 1980; Santos, 2005). This underlines the importance of experiential therapies.

In order to avoid the dominance of emotion, reflection/conceptualization (me) of the immediate experience (I) is needed. To get out of the mastery of thought or conscious mind, it is necessary to become open to immediate experience (I). How? Being a passive observer from its own experience. This is exactly what happens in daydream, fantasy, meditation, prayer, hope and faith. These phenomena are experienced in a direct and immediate way, without representation (Varela, Thompson & Rosch, 1993; Minkowski, 1995; Cavaco, 1999). Therefore, the immediate experience does not only include the immediate level of activity. This corresponds to the I-here-now - "I exist" (Minkowski, 1995); "Pleasant life" (Seligman, 2008). Individuals cannot persist at this level without being compromised. Here there is the risk for individuals to get dominated by their emotions. The immediate experience includes also the mediate level of desire - "I have" (Minkowski, 1995), "Good life" (Seligman, 2008) - which is a mode of extension of ourselves because it implies increased duration. The individual may stay longer in a contemplation state (what he has) without compromising its mental integrity. The immediate experience also includes the absolute level of the ethical action - "I belong to a community" (Minkowski, 1995), "Meaningful life" (Seligman, 2008) - which implies the fusion of the individual with its peers. At this level, the individual exceeds its egotism. Therefore, the immediate experience implies itself a future dimension, which is the deeper dimension of a lived experience (Minkowski, 1995). Consequently, this implies an *intellective* level of human activity and not only a sensitive one (Santos, 1999, 2005).

What is the relation of all this with anxiety? How could the differences between normal anxiety and pathological anxiety be defined?

Anxiety: activity, future and project

Guidano (1994) considers that the continuous reordering of experience is characterized at any time by possible discrepancies I/me, i.e., gaps perceived between immediate experience and self-consciousness, which challenge the current patterns of the individual or its organization of personal meaning. Thus, the pathology results from the difficulty of integrating the immediate experience (I) into the "me", or from the difficulty of integrating cognitive and affective aspects of experience. Taking into account the distinctions presented above, we can say that the problem is not between cognition and affection. Indeed, these two activities, although distinct, are inseparable and present at all levels of activity, from the most concrete to the most abstract. The transition from normal to pathological anxiety is due to the inability of the individual to move between immediate experience and reflection.

Anxiety is considered by most authors as an emotion (or mixture of emotions or emotional state), and it is identified with the automatic-unconscious process (*sensitive* level of activity), hence excluding all forms of abstract valuation (*intellective* level of activity). Consequently, the future dimension of human experience is also excluded. This means to reduce the human experience to the most concrete level of functioning and reduce human motivation to the binomial pleasure-displeasure. It becomes difficult to understand human achievements as well as the experience of continuity. The experience of continuity is a common experience to all healthy humans and constitutes what best defines the human being (Guidano, 1987, 1994, 1995). However, this experience of continuity is only possible by decision (*intellective* level), and not by emotion, which is transitional and limited in time. The emotion is only continuous in pathology (Santos, 2005).

When an individual is anxious, isn't that due to the fact of being divided between two or more values? Wouldn't the decision-making and initiative capabilities be jeopardized,

more than feelings or emotions? These activities are directly related to the personal project of each individual. If the individual hesitates, it does not decide; and if it does not decide, it does not act; if it does not act, it does not reach its goals, i.e., its projects (Santos 1999, 2005). There is a fact showing that anxiety is directly related to the project, and therefore it is something normal and even desirable - when an individual solves its problems, i.e., when he is able to decide, to act and to achieve its goals, anxiety disappears (Vaz Serra, 2003). Similarly, we can explain why we remember failures best rather than the successes – "Zeigarnick effect" (Seligman, 2007).

Although psychology (psychological health) should be distinguished from the clinical psychology (intervention in psychological pathology) (Santos, 1990), a meaningful life is the greatest achievement of both healthy and psychologically ill humans (Guidano, 1995; Mahoney, 1991, 1995; Santos, 1999, 2005; Seligman, 2008, 2011). The major difference is that in healthy humans, individuals can achieve this while, in the second case, individuals suffering from psychopathologies do not. This difference is significantly marked, particularly not at the level of the anxiety (frequency, duration and intensity) experienced (from a cognitive, physiological or motor level) by individuals, but rather in their achievements. In both healthy and pathological situations, the individual can experience high levels of anxiety because of being intensively *active*. However, in healthy people, this activity is oriented for one purpose (*project*), which will be achieved (materially feasible or not) in the *future*. In a pathological situation, the activity does not result in any realization. The symptoms, and not the project, are the center of the life of the individual.

If the problem is to assign meaning to the experience, what is the point on saying that individuals have an "emotional disturbance" or an "anxiety disorder"? Is the ability to stir emotions disturbed? Certainly not. It is because the autonomic nervous system functions that the individual manifests nervous, anxious, and excited. These "symptoms" are not the

problem, but a sign that a decisional problem is present. The individual hesitates due to the difficulty to prioritize; this may involve conscious or unconscious elements (hence the importance of awareness). The hesitation may be due to an insufficient analysis (*cognitive* aspect) or to a hasty appraisal/valuation (*affective* aspect). This could mean avoiding the risk or the incapacity to take decisions. In any case, the *intellective* level is involved (decision), as much as or more than the sensitive level (emotion).

Conclusion

If anxiety is directly related to the project of life, its investigation, either theoretical or clinical, should be prospective (to-the-front) rather than retrospective. What is really important is what the individual aspires, what it wants to accomplish or not yet realized; and not really the frequency, duration and intensity of the current anxiety experienced.

We should also investigate the "success stories" (those individuals who went through difficult situations but managed to overcome them) in order to identify and understand the factors involved. An excellent example is the English physicist Stephen Hawking.

The normal anxiety should be clearly distinguished from the pathological anxiety because the psychological/experiential processes involved are qualitatively different. This difference should be present in scientific terms in order to refer best to these different processes – this is a crucial aspect for a "de-psychopathology-zation" of the healthy experience of anxiety.

If a meaningful life is what defines the human being, this should also be the major goal in any psychotherapy. Seligman (2007) considers that the severity of the "wounds" do not predict the stress but the response of the individual. The same author suggests that the psychological disorders should be classified according to the subjective experience of the individual and not according to the stimulus.

Psychologically, anxiety is not pathology, it is *project*. This is not a cognitive error, is rather an *affective hesitation*. In pathological situations, there is no "anxiety disorder" but *decision-making disorder*.

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