



The Psychodynamics of Performance Anxiety: Psychoanalytic Psychotherapy in the Treatment of Social Phobia/Social Anxiety Disorder

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Abstract

The optimal treatment for Social Phobia/Social Anxiety Disorder (SP/SAD) remains an open question despite the existence of a variety of controlled studies, including randomized trials of cognitive behavioral and psychodynamic therapies. Moreover, individuals with Performance Anxiety, a colloquial term for SP/SAD, are typically treated by lay coaches and unlicensed practitioners, who focus on managing the symptoms of “stage fright.” This paper describes the psychodynamic (psychoanalytic psychotherapy) treatment of an individual with manifestations of SP/SAD in the realms of public speaking, musical performance, and professional accomplishments. The narrative identified contributions of childhood abuse, gender concept confusion, mismatched parent–child interactions, and conflicts concerning aggression and entitlement. It became clear that strong feelings associated with anxiety concerning self-worth were at play that left the patient no possible alternatives to wishes for idealized perfection. These findings served as the basis for a therapeutic approach from a self-psychology perspective that focused on empathy, shared emotional experiences, attunement, and being known. Psychoanalytic psychotherapy is a robust and potentially valuable option for individuals willing to undertake a more intensive therapy whose benefits extend beyond symptomatic relief.

Keywords Anxiety disorders · Psychodynamic therapy · Self-psychology · Gender concept

Social anxiety disorder (SAD; DSM-V 300.23); synonymous with Social Phobia (SP, ICD-10 F40.10) describes a condition where the sufferer experiences anxiety, fear, or panic “around social interaction, typically from concern about being embarrassed and judged by others.” The prevalence of SAD is said to about 15 million in the U.S. population (NIMH 2014). According to the NIMH, the treatment of SAD is comprised of medication, including anti-depressants, anxiolytics, sedatives, and Cognitive Behavioral Therapy (CBT). Other forms of therapy, notably including psychoanalytic psychotherapy, are not mentioned on the web site (NIMH 2014).

This focus on behavioral therapy, may be a result of the historically greater number of controlled trials for behavioral

therapies (notably CBT) and their greater amenability to standardization, compared with psychodynamic therapies (PDT) (Mayo-Wilson et al. 2014). Nevertheless, recent randomized and controlled studies by Leichsenring et al. (2014a, b) and coworkers demonstrated efficacy of standardized psychodynamic treatment in SAD, short and long-term. In the short-term (25 sessions over 6 months), both CBT and psychodynamic therapy were effective in SAD. CBT remission rates as defined by lower scores on a social anxiety instrument compared with PDT were significantly improved but, as the authors point out, the differences were small (36% vs. 26%). There was no significant difference in response rates between the groups (60% vs. 52%). At 2-years, however, response rates (70%) and remission rates (40%) were not different when comparing CBT and PDT. Of note, in another randomized study, Bögels et al. (2014) found no difference in outcome between CBT and PDT. In each study, as well as in an open trial by Lipsitz et al. (2014), 30–50% of patients were unresponsive to any therapy.

Performance anxiety is a colloquial term for the symptomatology of Social Phobia/Social Anxiety Disorder (SP/SAD)

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observed in the context of accomplishing a task that requires special skill, expertise, or talent and is also referred to conversationally as “stage fright.” Examples include fear of: public speaking or a less than perfect performance in sports, acting, or giving a concert. Recently, Sara Solovitch (2015) published a memoir, “Playing Scared: A History and Memoir of Stage Fright,” that narrates her life-long travails with SP/SAD at the piano. Her highly personal account is punctuated by multiple examples of stage fright in celebrities and adorned with detailed interviews with accomplished performers, who share their personal battles with the emotional ravages of SP/SAD. The book is excellent and, at a minimum, provides reassurance to individuals who suffer unaware that they are not alone. Here again, the absence of psychodynamic thinking is striking, even as Solovitch explores a variety of psychologies in addition to behavioral therapies. For Solovitch, invoking Freud automatically and invariably leads her to dismiss his approach as primitive and outdated. Although Jungian ideas are somewhat more acceptable to Solovitch, modern object relations theory, self, and relational approaches fail to make an appearance in her volume.

In fact, Freud (1936) and his followers evinced great interest in social anxiety quite early on in their attempt to understand the basic mechanisms of phobias. For example, Fenichel (1934) expounds on Freud’s focus an individual with social phobia who attempts to bolster a weak superego by way of obtaining self-esteem from others. Levy et al. (1995) elaborate upon Freud’s (1916/1957) description of individuals who avoid success or undermine their achievements (“Wrecked by Success”) as a result of developmental conflicts illustrated by the myth of Oedipus. They include envy and its consequences, trauma, and Kohutian concepts of grandiosity and exhibitionism in an attempt to understand patients who are unable to tolerate achievement in life and love:

While the vernacular of twentieth century psychoanalysis is less than user-friendly, these classical studies remain groundbreaking. I would like to offer a case of SP/SAD with dual manifestations of performance anxieties in music and professional (academic medical) accomplishment. It is my intent to update the earlier psychoanalytic observations in order to offer a dynamic understanding to the general psychological pathophysiology of SP/SAD. I intend to illustrate the enduring effectiveness of a self-psychologically-informed psychoanalytic approach, that is, one that is empathically focused on the conscious and unconscious, subjective experiences of self and others.

Case Report

Dr. Conrad presented as a 43-year-old man who was “in a panic” over an invited move to an academic appointment from his current position as a diagnostic radiologist in a

private practice group. Although possessing an academic bent ever since his medical and postdoctoral training, he was worried that he could not be successful in a position that required public speaking, supervision of students and residents, and the need to interpret, diagnose, and sign out a wide range of difficult cases. He had experienced difficulty with public speaking from an early age. Dr. Conrad recalled panic during his participation in a “roast” of his band director in high school and recounted a recent episode where, while delivering a scientific paper, he fainted, fell from the podium, and required stitches. Historically, he also experienced severe stage fright as a student musician, resulting in his abandoning aspirations for a professional career in music late in adolescence.

Dr. Conrad’s habitus was that of a tall, athletic, man who was open, verbal, and articulate, but tense. He manifested an intermittent intention tremor in his hands and side-to-side involuntary movements of his head. These symptoms had been present since latency age and had been evaluated neurologically with no specific cause established.

Tearily, Dr. Conrad recounted a haunting episode from his internship at a prestigious academic medical center. When faced with performing his first spinal tap, he was unable to go through with the procedure and left his post at the hospital without telling anyone, which led to his leaving the program and giving up his dream of becoming a surgeon. Psychotherapy with a psychiatric resident for about a year helped him transition to a career in diagnostic radiology but the memories of that episode continued to dog him into the present.

Dr. Conrad had intermittently tried propranolol for bouts of performance anxiety, mainly pertaining to public speaking. He felt it was “a placebo because it always stopped working.” He had taken no other medication previously and was on no medications at the time of presentation. I provided the diagnosis of Social Phobia (F40.10) for insurance purposes and we agreed to twice-weekly sessions seated face to face.

A few days into the diagnostic evaluation and discovery phase of the work, Dr. Conrad announced that he had accepted the academic offer, despite his feeling quite anxious and with the expectation of being more anxious in the upcoming days. In response to my query about what precipitated his decision he answered, “It was an opportunity I could not pass up. This allows me to connect with former classmates and colleagues who were also academics, and I like seeing my name on papers. Also, I would always regret passing this up.” He described writing on his bathroom mirror that day: (1) just for 2 years. (2) Don’t have to be perfect. (3) Just do your best. I offered my support for his decision and remarked that the mirror messages included the very important notion of having some wiggle room in his choices

(and noted to myself the aptness of this metaphor in terms of a transferential need for mirroring).

He ended the day's session with a request for medication. I suggested a low dose of alprazolam for "p.r.n." use in consideration of his aversion to propranolol, alprazolam's rapid onset of action, and the patient's demonstrated low risk for substance abuse but reminded him of the importance of keeping an eye on feelings and meanings. Later that afternoon he called with "buyer's remorse," in a panic at the imagined implications of his decision to take the job, which were identical to those he came in with. I reiterated the "wobble room" idea and expressed sympathy with the difficulty of the situation. I called in the prescription and offered an extra session for the following evening. I received an email the next day declining the added session, saying he had gone for a run and felt better. He also decided not to use alprazolam out of concern for becoming dependent. However, beginning his next session he informed me that he had formally reversed his decision and had abandoned the idea of going to academia. This choice was based on "feeling the immense weight of his decision's implications." He went on to describe the previous night's dream: "Two dogs, a big one and a diminutive one", were playing together and the big dog went down. The big dog got back up and happily trotted off in a playful manner. At the spot where the big dog had gone down it was discovered that the small dog then appeared to be dead, its neck broken by the large dog falling on him. But, the small dog turned out to be alive with legs moving. Dr. Conrad's associated to his being the small dog, crushed by his decision. The large dog represented the academic medical center, which didn't care about how he felt and could do fine without him. I offered my association that both dogs might be aspects of his self. The big dog might represent his wish for self-actualization and admiration, which is short-circuited by him in order to avoid the feelings of disappointment and shame if his efforts were not realized and appreciated by others. Also, the appearance of the big dog connects to his worries about the little one, exactly what happens when he goes for being special. He resonated with this as a death, recalling his anxiety at becoming the first chair clarinetist in his high school band and reframed my interpretation in terms of expectations (his and parents') to be perfect.

This recollection eventuated in a penetrating analysis of the film, "Whiplash," which portrays the at times abusive relationship between a drummer in a college band and his sadistic, perfectionist conductor. Dr. Conrad went on to report experiences of having been beaten by his father with a switch or belt on a regular basis. He tried to "let father off the hook" in terms of cultural acceptability of corporal punishment in former times in his part of the country and a wished-for need for father to "prod" him into better behavior. Dr. Conrad recalled an early episode where, practicing

his clarinet at home, he "lost it" after attempting a particularly difficult passage of music and inadvertently broke his clarinet in frustration, which led to a beating by father. I emphasized that these dynamics were likely etiological in his anxiety and involved mixed feelings (worry about "losing it," concern with pain, concern with abandonment). I made it clear that to my mind this experience was abusive, traumatic, and unacceptable.

He said that drama and rants were common in the household of his youth, mainly by his paternal grandmother and his father, who would "Go Chester" (that is, lose emotional control, just as Dr. Conrad did with his instrument) whenever he didn't get his way. For example, a rant against the restaurant hostess would inevitably come on if Dr. Conrad's father felt that the wait for seating were too long for him to tolerate. As a teenager and young adult, Dr. Conrad was mortified by this public display and exasperated by not being able to prevent his father's outbursts. I conjectured that the worry of going out of control should he react, even in the slightest, to errors or missteps reflects overwhelming fears that contribute to his performance anxiety. For his part, he again associated directly to the drama surrounding the spinal tap debacle and the aborted choice to go to academia.

I heard many such examples of unresolved conflicts in Dr. Conrad's narrative. In Dr. Conrad's current workplace there were numerous ongoing issues with the managing partner of his radiology practice. For example, Dr. Conrad felt that his own diagnostic acumen was not sufficiently recognized, his extra-curricular efforts on behalf of the practice were not appreciated, and he felt taken advantage of by the boss at times of salary negotiations and in deliberations attendant to his potentially purchasing a partnership in the enterprise. These he most acutely experienced as self-consciousness and physiological symptoms of tachycardia, sweating, and labored breathing whenever it was his turn to lead the radiologic case discussion conference, especially when his views were contravened by colleagues and, especially, by the leader (even if Dr. Conrad was confident in his opinion regarding the diagnosis).

As treatment progressed, more attention became focused on his gender concept and sexuality. Besides the implicit critique of his lack of typically "masculine" traits by his parents, his strongly felt need to hide his sexual interest in men took a great amount of emotional energy. When he finally came out during medical school, his parents failed to accept this reality for many years—although they did eventually. The residue of this dynamic was evident in many of the conflicts over a variety of choices Dr. Conrad faced. For example, we eventually understood that his rapid reversal regarding his application for the academic position was an attempt to appear decisive and, in his mind, masculine.

An additional facet of the involvement of his gender concept emerged during discussions of his imagined reactions

to manifesting physical symptoms of performance anxiety, notably during professional talks given under circumstances similar to the one where he fainted. His fantasy included the idea that the audience could see into him and detect his anxiety even before any outward manifestations. This would actually trigger the symptoms that would confirm for all the fact that he was innately, inordinately, and irreparably nervous. I asked him why having symptoms would be so problematic and he shared the belief that this would firmly characterize him as “female.” He remembered his mother’s response to an early episode of stage fright that she witnessed during his adolescence. She assured him that he was, “Just like me,” because she also did not enjoy being in the public eye and took care never to do so. His father’s disdainful response was also problematic: “You must think you’re special.” Apparently, for Dr. Conrad to evince nervousness is to be hysterical and female. The alternative—to be over aggressive, like father—was no better, leaving him in a sexual identity vacuum.

His inability to at times convey his needs and express his feelings of being unappreciated or neglected also seemed to be founded in views of what was appropriately male or female. For example, unless there was a clear, irrefutable, and demonstrably practical basis for his preferences, he ran the risk of appearing “flakey” or “flighty.” This state had to be avoided at all cost, lest he be judged as “hysterical” and like his vulnerable mother. Likewise, he was highly constrained at times when a decision needed to be made, as when his father, who was in a long-term-care facility in his home state for mental decline, had taken to leaving the facility un-announced. The staff suggested taking away father’s car keys, which was met with much resistance from both Dr. Conrad and his brother. In exploring the reluctance, Dr. Conrad acknowledged that he was uncomfortable with the aggressiveness of this act, which made him feel as if he were retaliating for his father’s aggression towards him. I added that the obvious concerns for the father’s safety as voiced by the facility director were de facto ignored and wondered aloud whether on some level this might in fact represent a retaliatory act, albeit a passive one. He agreed. I also questioned whether at the same time the safety of the public could end up being ignored, which eventually served as an entrée to exploration of his lack of protection by his parents. Dr. Conrad could see that the automatic quelling of these conflicted feelings (to protect and to injure) limited his choices severely and could lead to a dangerous outcome. This represented the beginning of his transition from seeing feelings as misleading and in need of squelching to embracing them as a guide to a wider range of choices and greater effectiveness overall.

After this exchange, Dr. Conrad tentatively began to raise the possibility of re-connecting with the academic chair, with the goal of exploring the possibility of assuming the

position he had declined. He was extremely concerned about this step being perceived as haughty but, at the same time, worried that he would be mocked for his vacillation. His anxiety rose with an extended delay in receiving a response, despite the knowledge that the chair faced many time-consuming obligations, particularly in mid-summer, the transition point of the medical academic year. Nevertheless, he persisted with requests for a face-to-face meeting, which was granted—with a gracious apology from the chair regarding the delay, explaining that he had been coping with an illness in the family. Eventually, Dr. Conrad’s proposal to initially work part time and transition to a permanent role was accepted by the chair.

As the paperwork and preliminary outlines of his new roles were percolating administratively, Dr. Conrad was able to address his troublesome relationship with the director of his current workplace, managed to give a funeral oration for a beloved uncle despite mounting anxiety leading up to the service, and began to explore his gender concept and sexual orientation more deeply. This part of our work occurred in the context of his asking his long-time partner to marry and their planning the wedding ceremony and party together.

All the while, Dr. Conrad revisited the vicissitudes of performance anxiety in his everyday work, including meeting teaching obligations that he had taken on in preparation for transferring to academia. These also included preparing to give a paper at the local radiological society and at a national board preparation program. Our discussions made it easier for him to face the anxieties of being judged adversely, despite his knowing that he was an accomplished researcher since his postdoctoral days and now was an experienced practitioner. We both read “Playing Scared” and discussed the films “Seymour: An Introduction” and “Love and Mercy” that depict, respectively, Seymour Bernstein’s life transitions and Brian Wilson’s psychological struggles, including performance anxiety for both these acclaimed musicians. These narratives seemed to allow him to take solace from the pervasiveness of this issue in prominent, successful artists.

Despite the initial encouraging response from the academic chair, progress on the paper work for his appointment stalled for many months. Dr. Conrad vacillated at the thought of pushing the matter, fearing a recapitulation of the initial dynamic. His emotions ranged from anxious to angry and he was able to give voice to both as part of our work. Somewhat suddenly, without asking for my input, Dr. Conrad responded to advertisements for part-time positions at a large community hospital and a government research facility. He interviewed at the former and surprised himself regarding how little anxiety he experienced during his meetings with the hiring authority and program director. He also flirted with the idea of applying for a position in music broadcasting but realized that he lacked training in this area

and, besides, the remuneration fell far short of his expectations and needs, much less than for medical work. A few weeks into the hiring process, Dr. Conrad shared an email he had sent to the Radiology Department Chair:

“Given the very long time that has elapsed in getting the part-time position off the ground, I have had ample time to seriously consider my future career plans, and at this juncture, I think it best that we scrap any further plans for me to move to the University on a part-time or full-time basis.

With the passage of time, it has become apparent that any such move would not be a good “fit” for me or the program. I am also looking to accomplish some personal goals that lie outside of my medical career (specifically in the area of support of the Performing Arts), and I think that the role at the University would hinder that.

I’m very sorry this did not work out, but I wish you and the organization all the best.”

I limited my comments to support for his decision and remarks taking note of the measured tone of his correspondence (thinking to myself of the mirror—this time of my style of speech and clinical posture). I had some angst about not cautioning or questioning with regard to his closing the door in the absence of any information regarding the true status of his appointment. Dr. Conrad shared the response of the Chair, who was, again, gracious and accepting of his decision, despite some defensiveness about the slowness of the Center’s response, and expressed the wish that Dr. Conrad might continue informal interactions with the University’s Radiology Department in the future.

When we next met, I asked Dr. Conrad about his reaction to the Chair’s response. He said, “Relief!” He immediately associated to the early dream of the “two big dogs and the little one” and recalled a real-life experience of seeing a similar scene when he was an adolescent in the back seat of the family car with his brother and sister-in-law. I shared my recollection of the first iteration of the dream as containing but one large dog. He agreed but conjectured that he included a revised memory of another big dog to represent the Vice Chair, a female, but still felt that the big dog symbolized the Department. I accepted this but added my association to his new elaboration along the lines of my earlier interpretation, offering the possibility that now he internally could acknowledge his “big dog” status—someone whose competence was not in doubt, neither in his mind nor in the perception of others.

I also shared my own relief concerning my worry about not having raised for discussion the matter of his possibly writing to me before clarifying the status of his application. Dr. Conrad brushed this off, saying he was sure about the action he took when he wrote and more so now. Just as

I thought the same thought, Dr. Conrad associated to his father’s waiting on line for dinner seating and declared, “My father could not do this. This is freedom.” He added that the vice chair admirably noted his future career intentions in the area of performing arts, saying that she too held the performing arts in high esteem and commented about how many people in their field felt the same way and stayed involved in the arts community.

Although I did not say so expressly, I had the impression that this part of his plan was motivated by a wish to repair the loss of his musical career. I found myself extremely moved, almost to tears, and could see that Dr. Conrad was similarly affected. He uttered, “I could not have done it without your help,” to which I responded, “It takes two to tango.” At the end of the hour we shook hands and hugged—our first physical contact during our time working together.

Clearly, Dr. Conrad had begun to see his anxiety as potentially a life-long challenge but amenable to reflection-mediated new behaviors, including the occasional use of Alprazolam, if needed. Armed with the insights, emotional understanding, and interactions in therapy that were diametric to the critical, often abusive, experiences of the past, he was able to better navigate a wider range of social and professional choices. These included enrollment in an advanced degree program in performing arts management and taking a position in a large community hospital, where his responsibilities included leading and presenting at clinical case conferences attended by colleagues from a variety of disciplines. Eventually he was able to carry out these duties without resorting to benzodiazepines. Shortly thereafter he indicated a desire to end treatment, which we agreed upon after a number of sessions devoted to the termination process.

Discussion

This clinical history illustrates the oft-observed performance anxiety-generating situation in which a high achiever strives to be seen as special. But, his pervasive worry that arriving in the spotlight will call others’ attention to his deficiencies engenders a confusing mix of feelings. This process occurs out of awareness. The symptomatology reflects the fact that the performer is stuck and not just in “Flight/Fight.” If he is less than perfect, it validates his unworthiness. At the same time, even if he performs brilliantly, the basic problem is not solved because the lacuna in self-esteem resides elsewhere, not in musicianship, medical diagnostic acumen, or academic performance. Rather, it is buried in forgotten memories of critical non-acceptance by early objects of affection and desired connection.

The case reported here can be viewed as paradigmatic of the psychodynamics of performance anxiety, including profound struggles with the regulation of aggressive affects as

originally described by Freud and most recently by ego psychologists such as Nagel (2018). Dr. Conrad demonstrated this by his “wrecked by success”-like Oedipal retreat from accomplishment (musical, medical procedural, academic, and personal) and with exaggerated worries over losing control (like father, as with the clarinet) or being helpless (like mother). More compelling to my mind is his recurring challenge of maintaining self-esteem in the face of having been overburdened by his parents’ “failures of attunement and unrepaired unempathic responses to his early developmental needs” (Geist 2016)—most notably evinced by their inability to accept his sexual orientation and their inability to esteem his musical talent. The long-term result of feeling disconnected and unprotected was continually re-experienced symptomatically whenever he entertained the prospect of approval and acceptance in performance in later life.

As in Dr. Conrad case, individuals with performance anxiety feel profoundly unsafe, with the attendant feelings and physiological manifestations of overwhelming affects. The audience, rather than being a source of appreciation and support, are transferentially experienced as distant, critical, and disapproving. The performer feels not just alone but exposed—as sufferers frequently remark—naked (“under the microscope”) or transparent (“under a fluoroscope”). The natural existential extension of this feeling state is, as Dr. Conrad described early on, “death.”

Dr. Conrad’s case is not unique with respect to the formulation contained here. Ethan Hawke’s acclaimed documentary film, “Seymour: An Introduction,” alluded to previously, documents these selfsame dynamics poignantly and pointedly. The documentary highlights Seymour Bernstein, a star concert pianist of the 1950s, who gives up his career at its apogee due to performance anxiety. Mr. Bernstein assumes an outstanding but more private career as a teacher, mentor, acclaimed author, and consultant to Steinway Pianos. But, even nearing 90, his recollection of his father’s describing his children as “two daughters and a musician” visibly pains him to his core. Similarly, T. H. White, described by Macdonald (2016) in, “H is for Hawk,” speaks of his spurious assumption that he needed to excel in order to be loved resulting in his sabotaging his success whenever doubts about his self-worth crept into his mind.

Sara Solovitch presents John Orlando, a prominent pianist, teacher, and concert organizer in her community who, like she, had, tried multiple approaches to his own performance anxiety, including EMDR (Eye Movement Desensitization and Reprocessing), without success. No mention is made of talk therapy as a modality, though. Using Orlando’s words, Ms. Solovitch, can track aspects of her own experience and comes as close to insight about the sources of her stage fright as anywhere in her account with her statement that “failing became a way for me to get back at them, a way of wanting to be accepted for myself alone.”

The resonance of Dr. Conrad’s experience to those of Bernstein, White, Wilson, and Orlando, makes unlikely the possibility that the dynamics portrayed by them are randomly represented.

So, how did treatment bring about the positive changes in Dr. Conrad’s anxiety and how may they be applied more generally? The simplest answer is that psychoanalytic psychotherapy provided him a safe space for re-experiencing, in narrative, the psychodynamic forces that underlay his symptomatology. In this protective environment he could learn to tolerate angry and shameful affects, regulate his anxiety, and replace archaic and limited automatic behaviors with new, more effective ones.

On a technical level, I believe this was accomplished in great part by way of basic self-psychological tenets of an idealizing transference, mirroring and twinship, and empathic immersion. Dr. Conrad could feel understood and, most importantly, known by being able to share his emotional experience that was met with empathic responsiveness. Dr. Conrad experienced me as calm and unflappable and took great solace from my stance that his symptoms made sense and his feelings real and justifiable. My empathic posture allowed him to model his approach to giving talks after my own (including a presentation I gave that he found on the internet). Our twinship evolved organically from a mutual identification as physicians, progressed through our shared interest in the movies and readings we took up together, and culminated in preparation of this article. Dr. Conrad embraced the idea of a publication, eager to help others who suffer from performance anxiety.

No doubt, there is an ongoing tension for individuals afflicted by SP/SAD between wanting to fix the problem (behaviorally) quickly via CBT or to manage it in the long-term by way of understanding and reframing (psychoanalytic psychotherapy or other PDT). The encounters with some behaviorists (especially those untrained in nuances of CBT) and coaches, including those described in “Playing Scared” strike me as traumatic and borderline abusive, beyond simply unempathic. The intense exhortations to focus, concentrate, visualize, etc., mirror (in a deleterious way) and recapitulate the exact dynamic evinced in the generation of social anxiety in the context of parental or educator abuse typical of many of Solovitch’s cases, the features in the case report here and elsewhere (Fosshage 2002; Nagel 2018), and in analyses found in multiple studies that report the association of verbal and physical abuse with SAD (Bandelow 2004; Bishop 2014; Magee 1999). It is as if SP/SAD sufferers need to perform the externally applied correctives “properly” and according to the dictates of the guru/parent. This focus on active behavioral interventions and symptom relief may work for some highly-motivated sufferers (if they feel protected enough) but ignoring the pervasive consequences of abuse would

appear to be an extremely high price to pay, especially if the problem and its sequelae in other areas of life continue to recur.

The symptoms of stage fright are not just physiological consequences of amygdala stimulation mediated by adrenaline. They are manifestations of an emotional conflict between craving praise and dreading not receiving it; wishing for adulation amidst the worry that it is undeserved. Disappointment, shame dynamics, narcissistic sensitivities, developmental issues, and terrors pertaining to both psychic and bodily disintegration fuel the raging symptomatology of performance anxiety and its attendant panic (Nagel 2018). In contrast to behavioral therapies, the approach of dynamic treatments (psychoanalytic psychotherapy) does not attempt to deny or defeat the affects central to the genesis of SP/SAD. Rather, PDT promotes patients' tolerance of these panic-laden affects, within the context of an empathic, supportive, and understanding protective relational environment. This process, as described extensively in the treatment of Dr. Conrad, gives the patient the opportunity to address both the index symptoms and wider reaching structural self-issues, thereby giving him a much more complete picture of his personality, temperament, abilities, and life options.

The recent controlled trials of PDT give weight to its use as a primary treatment for SP/SAD, offering patients and psychotherapists a wider array of defined, personalized interventions, thereby making effective treatment more likely. This extended case report provides a treatment model for those choosing a psychodynamic approach and enhances the scientific and medical validity of doing so by providing meaningful observations and insights that nomothetic research, including clinical trials, cannot access (Dodes and Dodes 2017). Although the form of PDT implemented here was based primarily on Psychoanalytic Self-Psychology, this does not imply that other approaches utilizing concepts from other psychoanalytic disciplines including ego, object relations, Jungian, Lacanian, etc., would not be effective. Indeed, this case points to future research that would compare treatment approaches and establish efficacy in studies employing a variety of perspectives. The fact that so many subjects in the literature failed to benefit from any therapy opens the way for the application of a more intensive therapy: one whose lasting impact can go beyond performance, deep into the core of self.

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Compliance with Ethical Standards

Conflict of interest Author declares that he has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institute for Contemporary Psychoanalysis and Psychotherapy and with the 1964 Helsinki declaration and its later amendments.

Informed Consent Informed consent was obtained from the individual included in the study.

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