

# ANXIETY STATE

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## Introduction and Definitional Context

The term **Anxiety State** holds significant historical weight within the field of psychology and psychiatry, particularly in early psychoanalytic and descriptive nosology. Broadly, it refers to a psychopathological condition characterized by intense, pervasive, and often debilitating anxiety that appears disproportionate to any specific external threat or identifiable stimulus. While modern diagnostic systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), have largely replaced this specific designation with more nuanced categories--such as Generalized Anxiety Disorder (GAD) or Panic Disorder--understanding the **Anxiety State** is crucial for tracing the historical evolution of psychopathology, especially its relationship to the foundational concepts of **anxiety neurosis**. Historically, the diagnosis served as a pivotal conceptual bridge between purely physiological manifestations of distress and the burgeoning understanding of psychogenic origins of emotional suffering.

The classical understanding of the **Anxiety State** emphasizes the subjectively distressing feeling of dread, apprehension, and impending doom, often accompanied by a range of somatic symptoms. These physiological markers typically include palpitations, shortness of breath, dizziness, sweating, and muscular tension, reflecting a chronic activation of the autonomic nervous system. Unlike temporary fear, which is a rational response to immediate danger, the anxiety state is enduring and free-floating, meaning the individual struggles to pinpoint the precise source of their distress, leading to significant functional impairment across occupational, social, and personal domains. This chronic presentation necessitated careful differentiation from conditions where anxiety was clearly secondary to another primary disorder, thereby establishing the **Anxiety State** as a primary diagnostic entity in its own right during the late 19th and early 20th centuries.

It is imperative to note the definitional overlap and subsequent divergence between the **Anxiety State** and the broader category of **Anxiety Neurosis**. In some historical frameworks, the Anxiety State described the acute clinical presentation or syndrome, whereas Anxiety Neurosis encompassed the underlying psychodynamic structure or chronic disposition leading to such states. Referencing the original formulation, the concept directs scholars to consult **anxiety neurosis**, underscoring this intimate historical connection. The subsequent sections will detail how this conceptualization was dramatically specialized and refined when applied to specific environmental pressures, namely the trauma experienced during wartime, shifting the focus from internal disposition to external precipitating factors interacting with internal psychological conflicts.

## Historical Psychoanalytic Foundation: Sigmund Freud

The seminal contributions of **Sigmund Freud** were paramount in establishing and defining the conceptual boundaries of the **Anxiety State**, particularly within the context of early psychoanalytic theory. Freud initially categorized various anxiety conditions, differentiating between those rooted

primarily in physiological factors (actual neuroses) and those stemming from psychological conflict (psychoneuroses). The initial understanding of the Anxiety State often leaned toward an "actual neurosis," where anxiety was seen as resulting from the damming up of libido or frustrated sexual excitation, manifesting directly as physiological anxiety symptoms without complex symbolic elaboration. This early formulation provided a crucial, though subsequently revised, framework for understanding anxiety as a fundamental psychobiological phenomenon.

Freud's later, more influential, revision--detailed primarily in "Inhibitions, Symptoms, and Anxiety" (1926)--repositioned anxiety from merely a result of blocked energy to a central signal function of the ego. In this updated model, anxiety is understood as a response to perceived danger, specifically the danger posed by instinctual demands threatening to overwhelm the ego, or the threat of loss of the protective love object. This transition from physiological accumulation to psychological signaling allowed for a much richer understanding of the **Anxiety State**, moving the focus toward internal defensive operations and the structure of the psyche. It is within this revised framework that the specific application of the **Anxiety State** to traumatic wartime experience gained its deepest psychoanalytic resonance.

Crucially, the definition of the **Anxiety State** as linked to **traumatic neurosis**, especially concerning wartime experience, is explicitly attributed to Freud's observational and theoretical work following World War I. The sheer scale and intensity of psychological breakdown observed in soldiers challenged existing diagnostic categories, forcing a consideration of how overwhelming environmental stress could induce profound psychological disturbances. Freud recognized that the specific psychological conflict involved in these cases--the clash between the imposed necessity of violence and deep-seated moral convictions--provided a unique window into the mechanics of the ego's breakdown under extreme pressure, solidifying the term's specific usage within trauma literature.

## The Context of Traumatic Neurosis and Wartime Experience

The application of the term **Anxiety State** was historically most specific when describing a form of **traumatic neurosis** precipitated by involvement in warfare, frequently referred to in earlier literature as "shell shock" or "war neurosis." During the major conflicts of the 20th century, military psychiatry grappled with the widespread phenomenon of soldiers exhibiting severe psychological distress, including persistent anxiety, dissociation, physical symptoms lacking organic cause, and an inability to function. The formal categorization of these intense reactions as an **Anxiety State** reflected the view that the extreme, life-threatening environment acted as a primary trauma, overwhelming the individual's capacity for psychological integration and adaptive coping.

Prior to this specific application, traumatic neuroses were often poorly understood, sometimes misattributed to malingering or simple physical exhaustion. The psychoanalytic framework,

however, provided a sophisticated mechanism for explaining these symptoms, focusing on the psychological impact of repeated, inescapable threats coupled with moral compromises inherent in combat. The **Anxiety State**, in this context, was thus understood not merely as nervousness, but as a severe reaction wherein the individual's psychic apparatus had been structurally damaged or functionally compromised by the traumatic exposure. This historical specialization remains a significant marker in the evolution of trauma psychology, foreshadowing modern concepts of Post-Traumatic Stress Disorder (PTSD).

The defining feature of this particular manifestation was the recognition that the traumatic experience could not be assimilated into the pre-existing psychological structure, leading to a pathological return of the event through intrusive memories, nightmares, and chronic hyperarousal--the hallmark symptoms of the **Anxiety State**. The environmental factor--the **wartime experience**--was seen as the necessary trigger that unlocked a specific internal conflict, shifting the focus away from general dispositional anxiety and toward the interactive effect of terror and moral responsibility. The soldier's inability to reconcile the actions required for survival in combat with their fundamental moral compass proved to be the specific psychological fuel for this severe condition.

### Conflict of Ego-Ideals: The Core Mechanism

Central to Freud's definition of the **Anxiety State** related to war neurosis is the concept of the **conflict of ego-ideals**. The ego-ideal represents the standards of moral and social behavior that the individual strives to meet; it is an internalized image of how one ought to be. Customary ideals held by individuals, often rooted in societal norms and religious or ethical teachings, typically prohibit violence, murder, and destructive behavior. However, the military imperative during **wartime experience** demands the complete suspension of these customary ideals, requiring the individual to adopt new, transient ideals centered on aggression, destruction of the enemy, and unquestioning obedience.

The development of the **Anxiety State** occurs precisely when the ego finds itself caught in an irreconcilable conflict between these two powerful sets of ideals. The soldier is psychologically torn: adherence to the wartime ego-ideal (the necessity of killing for survival or duty) directly violates the deeply ingrained customary ego-ideal (the prohibition against killing). The ego, unable to synthesize these conflicting demands without profound compromise, generates severe anxiety as a protective signal against this internal disintegration. The example provided illustrates this perfectly: "The soldier who experienced an **anxiety state** felt traumatized because killing others conflicted with his or her customary ideals." This trauma is not merely fear of death, but the psychological agony derived from moral injury.

This severe internal discord leads to feelings of guilt, shame, and self-reproach, which are then

compounded by the persistent terror of the combat environment. The anxiety is thus a dual response: a signal of external danger, and more profoundly, a signal of internal moral collapse. The psychic energy required to suppress the awareness of violating one's own ethical core, while simultaneously surviving the external threat, overwhelms the ego's defensive capacities, resulting in the chronic, debilitating symptoms characteristic of the **Anxiety State**. This explanatory model provided a sophisticated, dynamic understanding of war trauma far superior to simple physiological explanations.

## Clinical Manifestations of the Anxiety State

The clinical presentation of the **Anxiety State**, particularly in its historically defined traumatic form, is marked by a cluster of symptoms reflecting chronic hyperarousal, avoidance, and emotional dysregulation. Patients typically display persistent vigilance, an exaggerated startle response, and severe insomnia due to intrusive thoughts and nightmares that often replay aspects of the traumatic event or the associated moral conflict. Somatic symptoms, reflecting the body's inability to return to a baseline state of calm, include chronic muscle tension, irritable bowel syndrome, and functional cardiovascular complaints such as tachycardia and premature ventricular contractions, all contributing to the individual's profound sense of illness and impending catastrophe.

Furthermore, individuals suffering from an acute **Anxiety State** often exhibit marked difficulty concentrating and memory impairment, particularly concerning non-traumatic events, as their psychic resources are predominantly allocated to managing internal distress and scanning the environment for perceived threats. Avoidance behaviors are also prominent; the patient attempts to steer clear of any stimuli--places, people, conversations, or even thoughts--that might trigger a recollection of the traumatic event or reactivate the moral conflict. This avoidance can lead to severe social isolation, further exacerbating the feeling of helplessness and alienation that characterizes the underlying neurosis.

The cyclical nature of the **Anxiety State** ensures its persistence. The chronic physical discomfort and sense of impending doom fuel metacognitive worries about the anxiety itself ("What if I lose control?", "Am I going crazy?"), which in turn intensifies the physiological symptoms, creating a positive feedback loop. This intense focus on internal state, coupled with the inability to find psychological resolution for the conflict of ideals, renders the individual functionally crippled, demanding intensive therapeutic intervention focused on both symptom management and the underlying psychological compromise.

## Differentiation from Anxiety Neurosis (Generalized Anxiety Disorder)

While the **Anxiety State** and **Anxiety Neurosis** are closely related historically--the former often being an acute manifestation of the latter--modern classification systems require careful

differentiation, particularly when comparing the historical concepts to current diagnoses like Generalized Anxiety Disorder (GAD). GAD, which aligns conceptually with chronic Anxiety Neurosis, is characterized by persistent, excessive worry about a number of events or activities (e.g., work, health, finances) over a prolonged period. The anxiety is diffuse, often unfocused, and not necessarily tied to a single, overwhelming traumatic event or profound moral conflict.

In contrast, the historical **Anxiety State**, especially in its traumatic context, possessed a discernible, though repressed, etiology: the overwhelming **wartime experience** and the specific **conflict of ego-ideals**. The symptoms were understood as a direct result of the ego's failure to process this specific, highly charged experience. While both conditions involve chronic worry and somatic symptoms, the traumatic Anxiety State features more prominent symptoms of re-experiencing (flashbacks, nightmares) and heightened arousal specifically linked to the trauma, elements that place it closer to modern PTSD rather than pure GAD.

Therefore, the shift in terminology reflects an evolution in understanding etiology. The historical **Anxiety State** highlights the disruptive power of external events colliding with internal moral structure, whereas GAD/Anxiety Neurosis emphasizes a more generalized, perhaps constitutional, predisposition toward chronic worry and autonomic instability, often lacking the singular moral trauma at its core. Recognizing this distinction is vital for accurate historical interpretation of psychiatric records and the development of trauma-informed approaches.

## Psychodynamic Interpretation of Anxiety States

From a psychodynamic perspective, the **Anxiety State** stemming from trauma is interpreted as a failure of the ego's primary defensive functions. The ego, tasked with mediating between the demands of the id, the constraints of reality, and the moral restrictions of the superego (which contains the **ego-ideals**), is overwhelmed by the traumatic input. The sheer intensity of the experience, coupled with the moral necessity of violating deeply held beliefs, leads to a massive influx of unmanageable excitation. The anxiety itself is the manifestation of the ego's desperate attempt to master this influx and avoid psychological fragmentation.

The specific mechanism of the war-related **Anxiety State** involves the mobilization of primitive defense mechanisms, such as massive repression or dissociation, to cope with the intolerable reality of the moral conflict. However, these defenses inevitably fail, leading to the return of the traumatic material and the underlying conflict, manifesting as intrusive symptoms and chronic anxiety. The soldier cannot integrate the experience of having killed others, or having witnessed unspeakable horrors, with their identity as a civilized, moral being. The resulting psychological gap generates the persistent, debilitating anxiety that defines the state.

Furthermore, psychoanalytic theory posits that the chronic nature of the **Anxiety State** can be maintained through repetition compulsion--the unconscious drive to repeat or master the traumatic

event. In this state, the individual unconsciously places themselves in situations, real or symbolic, that recreate the conditions of the initial trauma, not to resolve it, but to perpetually relive the feeling of overwhelming helplessness, thereby cementing the neurosis. Successful treatment, therefore, must involve not just symptom relief, but the gradual and safe lifting of repression to allow the ego to integrate the traumatic experience and reconcile the conflicting **ego-ideals**.

## Etiology and Predisposing Factors

While the immediate cause of the historically defined **Anxiety State** was the **wartime experience**, etiology is never purely external; it involves the interaction of environmental stressors with predisposing individual vulnerabilities. Predisposing factors contributing to the development of a severe **Anxiety State** include pre-existing neurotic tendencies, developmental histories marked by early loss or trauma, and specific personality traits such as heightened sensitivity or rigidity. Individuals with weaker ego structures or those who possess particularly stringent and inflexible **ego-ideals** may be less equipped to handle the moral and existential compromises demanded by combat.

Biological and physiological factors also play a significant role. Differences in autonomic nervous system reactivity, genetic predisposition to anxiety disorders, and neuroendocrine responses to stress can determine the severity and persistence of the anxiety symptoms following trauma. While Freud emphasized the psychogenic conflict, modern understanding recognizes that extreme stress fundamentally alters neurochemical pathways, leading to chronic dysregulation of the HPA axis and amygdala hyperactivity, which chemically reinforces the hyperarousal characteristic of the **Anxiety State**.

Sociocultural factors also contribute significantly to the vulnerability profile. The degree to which a society validates or condemns the actions required in war can influence the intensity of the **conflict of ego-ideals**. If a soldier feels unsupported or misunderstood upon returning, the process of psychological recovery is severely hampered, perpetuating the state of anxiety. The collective trauma and societal expectation placed upon the returning soldier further complicates the individual's ability to resolve the conflict between the wartime duty and their customary moral ideals, locking them into the debilitating neurosis.

## Therapeutic Approaches in Historical Context

In the historical context in which the **Anxiety State** was defined, therapeutic approaches varied widely, ranging from purely somatic treatments to emerging psychotherapeutic methods. Early treatments for war neuroses often included rest cures, electrical stimulation, or hypnosis, aimed primarily at alleviating the paralyzing physical symptoms and restoring basic functioning. These methods often achieved temporary relief but failed to address the underlying psychological conflict

associated with the clash of **ego-ideals**.

Psychoanalytic treatment, consistent with Freud's framework, aimed to bring the repressed traumatic material and the associated moral conflict into conscious awareness. The goal was to facilitate the ego's working through of the conflict, allowing the soldier to integrate the wartime experience and modify the rigid **ego-ideals** that were being violently transgressed. This process involved lengthy free association, dream analysis, and transference interpretation, focusing on the psychological necessity of the symptom (anxiety) as a defense against a worse internal collapse.

Later psychological interventions, including early forms of behavioral therapy and cognitive approaches, began to focus more directly on symptom reduction, particularly managing the chronic hyperarousal and avoidance patterns. Techniques such as systematic desensitization sought to gradually reduce the patient's sensitivity to anxiety-provoking stimuli. While modern treatments for trauma-related anxiety states are significantly more sophisticated, integrating trauma-focused cognitive processing and exposure therapies, the historical treatment of the **Anxiety State** laid the groundwork by acknowledging the profound psychological necessity of confronting, rather than merely suppressing, the traumatic memory and its associated moral anguish.

## Evolution into Modern Diagnostic Frameworks

The specific diagnostic term **Anxiety State**, especially linked to **traumatic neurosis** and **wartime experience**, has largely been absorbed and superseded by modern, empirically grounded diagnostic categories. Most significantly, the constellation of symptoms defined by the traumatic **Anxiety State**--including chronic hyperarousal, intrusive re-experiencing, and avoidance--align almost perfectly with the criteria for **Post-Traumatic Stress Disorder (PTSD)** in current nosology. PTSD explicitly recognizes the role of external trauma as the necessary precipitant, thereby maintaining the core etiological link identified in the Freudian definition of the war neurosis.

Furthermore, elements of the non-traumatic **Anxiety State**, characterized by pervasive, unfocused worry and chronic somatic complaints, are now categorized primarily under **Generalized Anxiety Disorder (GAD)** or, if characterized by acute, episodic attacks, **Panic Disorder**. The evolution reflects a move away from the singular concept of "neurosis"--which implied a core internal psychological conflict--toward more descriptive, symptom-based classifications that facilitate standardized research and pharmacological intervention.

Despite the obsolescence of the specific term, the historical concept of the **Anxiety State** remains critically important for understanding the psychopathology of moral injury. Freud's emphasis on the **conflict of ego-ideals** provides a profound theoretical basis for understanding the non-fear-based dimensions of trauma, recognizing that psychological injury can stem from violations of one's own moral framework as much as from physical threat. Thus, while the label has changed, the underlying dynamic mechanism identified by the early psychoanalysts continues to inform deep

psychological understanding of trauma and anxiety disorders today.

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