

ANXIETY STATE

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1. Core Definition

The term **Anxiety State** refers historically to a persistent and distressing psychological condition characterized by pervasive apprehension, internal tension, and significant physiological arousal. While modern diagnostic systems prefer more specific categorizations (such as Generalized Anxiety Disorder or Panic Disorder), the concept of the **Anxiety State** was crucial in early 20th-century psychopathology, distinguishing between normal, transient reactions of fear and chronic, debilitating clinical conditions. It represented an observable syndrome where anxiety was the central and primary manifestation of underlying internal conflict or overwhelming external trauma.

In classical psychoanalytic theory, particularly as developed by Sigmund Freud, the concept evolved considerably. Initially, Freud differentiated between "actual neuroses" (including Anxiety Neurosis) which were thought to arise directly from contemporary sexual factors or accumulated physiological tension, and "psychoneuroses" which involved repressed psychological conflicts. The **Anxiety State**, when viewed as a severe, acute reaction, blurred these lines, particularly when precipitated by external, life-threatening stressors, suggesting a critical breakdown in the ego's capacity to manage overwhelming stimuli.

Crucially, an **Anxiety State** is characterized by its endurance and generalization--the distress is not confined to a single moment or object but colors the individual's entire emotional landscape. Symptoms typically include a constant sense of dread, restlessness, hypervigilance, and various somatic complaints like palpitations, sweating, and difficulty breathing, often leading to significant impairment in social and occupational functioning. This conceptualization formed the foundation for later, more nuanced understandings of clinical anxiety disorders.

2. Etymology and Historical Development

The formal conceptualization of the **Anxiety State** took root in the late 19th century, emerging from the broader classifications of neuroses that dominated European psychiatry. Before this definition, similar presentations were often grouped under vague diagnoses such as neurasthenia or hysteria. Sigmund Freud was instrumental in isolating and defining the condition, initially classifying it under the category of "actual neuroses" alongside hypochondriasis and neurasthenia, suggesting a direct toxic or physiological etiology stemming from inadequate sexual discharge or management.

However, the conceptual significance of the **Anxiety State** was dramatically amplified by the demands of the First World War. The widespread phenomenon of "shell shock"--severe, non-physical psychological collapse experienced by soldiers--challenged existing medical paradigms. It

was in analyzing these combat-related reactions that the term was heavily associated with **traumatic neurosis**. Psychiatrists realized that massive external trauma could directly generate profound anxiety syndromes that resisted simple physical or psychological explanations based purely on internal conflicts.

During this period, the **Anxiety State** was frequently used interchangeably with or as a primary manifestation of traumatic neurosis, especially when the symptoms were acute and clearly tied to a specific, overwhelming event. This historical evolution underscores a fundamental shift in understanding: moving from anxiety as solely a byproduct of internal, repressed wishes to acknowledging anxiety as a direct, crippling response to exogenous environmental danger that shatters the individual's sense of safety and self-cohesion.

3. The Traumatic Neurosis Context and Conflict of Ideals

One of the most defining and specialized applications of the **Anxiety State** classification stemmed from its use as a synonym for, or consequence of, **traumatic neurosis**, particularly in the context of warfare. This specific definition, closely tied to Freudian analysis of soldiers returning from combat, highlights a crucial dynamic: the conflict between opposing sets of internalized ethical standards. The source content explicitly notes that this manifestation occurs because the **ego-ideals of war conflict with customary ideals**.

The **ego-ideals of war** represent the demands and expectations of the military environment--duty, aggression, courage, the necessity of killing the enemy, and the suppression of fear. Conversely, the **customary ideals** represent the individual's lifelong moral and ethical framework, often rooted in societal prohibitions against violence, the value of human life, and personal safety. When a soldier is forced by circumstance to violate these deeply held customary ideals (e.g., by killing others) in the service of the temporary, extreme ego-ideals of war, the resulting psychological tension becomes unbearable.

The trauma, therefore, is not merely the physical danger experienced but the internal ethical dissonance. The classic example provided is that of the soldier who experiences an **anxiety state** because "killing others conflicted with his or her customary ideals." This severe, unresolvable conflict overwhelms the ego's ability to synthesize and cope, leading to the debilitating anxiety syndrome. This formulation provided an early and powerful explanation for combat-related mental distress, positioning the moral injury, rather than just the physical threat, as the primary source of the neurotic state.

4. Relationship to Anxiety Neurosis and Modern Classifications

Historically, the **Anxiety State** was considered to be highly related to, or perhaps a severe presentation of, **anxiety neurosis**. Before the standardization provided by the DSM (Diagnostic

and Statistical Manual of Mental Disorders), the diagnosis of anxiety neurosis encompassed a broad spectrum of non-psychotic conditions where anxiety was the primary feature, often including what we would now term panic attacks, phobias, and chronic worry. The specific label of **Anxiety State** was often reserved for the most acute, incapacitating manifestations of this underlying neurosis.

The distinction between the two was sometimes drawn based on etiology: Anxiety Neurosis was seen as more endogenous, rooted in internal conflicts (a failure of repression or management of libidinal impulses, in Freudian terms), whereas the specific **Anxiety State** was often triggered by an identifiable exogenous shock (the trauma). Nevertheless, in practice, the symptomatology overlapped significantly.

In contemporary psychiatry, the term **Anxiety State** is obsolete, having been replaced by highly differentiated categories introduced primarily with DSM-III (1980). The clinical presentations formerly described as an **Anxiety State** have been absorbed into several modern diagnoses, most notably:

Generalized Anxiety Disorder (GAD): For chronic, non-situational worry and tension that mirrors the generalized distress of the classic Anxiety State.

Panic Disorder: For recurrent, acute episodes of intense fear and physical symptoms that were often features of a severe Anxiety State.

Post-Traumatic Stress Disorder (PTSD): This diagnosis is the direct successor to the concept of traumatic neurosis, explicitly addressing the overwhelming anxiety, hypervigilance, and conflict symptoms tied to catastrophic external events, directly replacing the combat-related definition of the Anxiety State.

5. Key Characteristics and Manifestations

The historical description of the **Anxiety State** details a specific cluster of psychological and physical symptoms that collectively signify a profound disruption of the autonomic nervous system and the ego's regulatory functions. These characteristics helped clinicians differentiate it from other neuroses like obsessional or hysterical conditions.

The primary manifestations included:

Pervasive Apprehension and Dread: A constant feeling that something terrible is about to happen, often vague and non-specific, distinguishing it from phobias where the fear object is identifiable.

Somatic Hyperarousal: Physical symptoms were paramount, often including tachycardia (rapid heart rate), hyperventilation, dizziness, trembling, and profuse sweating. These physical signs were initially interpreted by some theorists as the primary complaint, rather than a secondary

manifestation of psychological distress.

Motor Tension: Restlessness, inability to relax, chronic muscle tension, and difficulty initiating or maintaining sleep (insomnia).

Hypervigilance: An exaggerated startle response and intense preoccupation with potential threats, a characteristic particularly pronounced in the traumatic neurosis variant following exposure to danger.

What characterized the **Anxiety State** was the difficulty in locating the source of the anxiety. Unlike rational fear, which dissipates once the threat is removed, the anxiety in this state persisted, signaling an internal mechanism (be it repressed conflict or the internal residue of trauma) that kept the alarm system permanently activated, rendering the individual incapable of returning to a baseline emotional equilibrium.

6. Significance and Impact

Despite its diagnostic obsolescence, the concept of the **Anxiety State** holds significant historical importance within psychiatry and psychology. It served as a critical intellectual bridge, moving clinical focus away from purely organic or degenerative causes of mental illness toward a deeper appreciation of psychological trauma and internal conflict as pathogenic factors.

Firstly, it validated the experience of severe anxiety as a legitimate, debilitating medical condition warranting treatment, rather than simply moral weakness. Secondly, its association with traumatic neurosis forced the scientific community, particularly during the inter-war period, to seriously engage with the psychological consequences of military combat and large-scale disaster. This work laid the groundwork for research into stress responses and eventually led to the development of modern trauma-focused diagnostics and therapies.

Furthermore, Freud's use of the **Anxiety State** to illustrate the conflict between ego-ideals and customary ideals provided a powerful psychoanalytic mechanism for understanding moral injury--a concept that remains highly relevant in contemporary military and humanitarian psychology. The focus on internal conflict generated by external circumstances remains a core tenet in various psychodynamic approaches to anxiety management.

7. Debates and Criticisms

The concept of the **Anxiety State** faced several criticisms, primarily concerning its lack of specificity and its foundation in psychoanalytic metapsychology, which proved difficult to empirically validate.

One major criticism was the ambiguity surrounding its etiology. Early Freudian definitions often shifted, sometimes linking the state to purely physiological causes (actual neurosis) and at other

times to complex psychological conflicts (traumatic neurosis). This inconsistency made reliable diagnosis and standardized treatment challenging for practitioners outside the psychoanalytic school.

A second criticism, which ultimately led to its abandonment, was its broad scope. By encompassing chronic tension, acute panic, and trauma reactions under a single umbrella, the term failed to provide the necessary precision for clinical research and pharmacological intervention. The rise of descriptive psychiatry emphasized the need to isolate distinct symptom clusters, such as those defining Panic Disorder or Specific Phobia, which could be studied and treated separately. The contemporary shift toward the DSM's polythetic criteria demanded greater specificity than the generalized diagnosis of **Anxiety State** allowed.

Further Reading

[Sigmund Freud: Life and Work](#) (Wikipedia)

[Neurosis](#) (Wikipedia)

[Diagnostic and Statistical Manual of Mental Disorders \(DSM-5\)](#) (American Psychiatric Association official site)

[Shell Shock and Traumatic Neurosis](#) (Wikipedia)