ANXIETY – GENERAL BACKGROUND OF ANALYSING THE PATHOLOGICAL PHENOMENON AND NORMAL EMOTIONAL MOOD

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Abstract: *All persons experience feelings of anxiety; it is a normal and positive dimension of human life and does not refer only to exaggerated worries. There is a distinction between the healthy and unhealthy anxiety, describing the first one as a concern and vigilance which helps people coping with different or difficult situations; the unhealthy anxiety is an emotional response to the threats perceived as real, but which are largely imaginary due to a very low probability of occurrence. Yerkes and Dodson (apaud Tyrer, 1999) have shown that anxiety has an unusual relation with performance. The pathological forms of anxiety are listed. The cognitive model of anxiety, which is seen as an adaptive response to the environment, starts with the perception of threat in a specific situation, the meaning that people attach to the situation is determined by their schemes and the memory of their past similar situations. The behavioural theories postulate that anxiety is a conditioned response to specific environmental stimuli.*

Cuvinte cheie: *anxietate, anxietate și performanță, anxietate normală și patologică*

Rezumat: *Toate persoanele experenţiază anxietate, ea reprezintă o dimensiune normală şi pozitivă a vieţii umane şi nu se referă doar la grijile exagerate. Se prezintă distincţia între anxietatea sănătoasă şi nesănătoasă, descriind-o pe prima ca îngrijorare sau vigilenţă care ajută oamenii să facă faţă situaţiilor diferite sau dificile; anxietatea nesănătoasă este un răspuns emoţional faţă de pericolele percepute ca fiind reale, dar care sunt în mare parte imaginare din cauza unei probabilităţi foarte mici de apariţie. Yerkes şi Dodson (apaud Tyrer, 1999) au arătat că anxietatea are o relaţie neobişnuită cu performanţa. Sunt listate formele patologice ale anxietății. Modelul cognitiv al anxietății, în care fiind privită ca un răspuns adaptativ la mediu, începe cu percepţia ameninţării într-o situaţie specifică, înţelesul pe care persoanele îl ataşează situaţiei este determinat de schemele lor şi de memoria unor situaţii similare din trecutul lor. Teoriile comportamentale postulează că anxietatea este un răspuns condiţionat la stimuli specifici din mediu.*

All persons experience feelings of anxiety. Typically, it is characterized by diffuse or intense fear, unpleasant, vague, often accompanied by autonomous symptoms such as headaches, sweating, palpitations, tightness in chest, stomach discomfort and agitation, indicated by the inability to sit still for a long period of time. This particular constellation of symptoms during anxiety tends to vary from person to person depending on the type of anxiety disorder.

Anxiety does not refer only to exaggerated worries; troubles are normal. The average levels of anxiety are often benefic to increase anyone's capability and those relatively high may be considered normal in certain circumstances. The people suffering from anxiety disorders do not only complain about the fact that they often feel restless, but call for support in order to deal with certain recurring fears they consider unreasonable and annoying.

Wilde (6) said that "anxiety is not caused by events but by our perception of events". In case of children and young people, for instance, this idea is often complicated by their cognitive abilities that might interfere with the ability to perceive events correctly; they naturally tend to extrapolate the ideas from one context and then to apply them inappropriately to other situations that might be totally different.(5)

Ellis (2) notes that there are many types and levels of anxiety. He distinguishes between the healthy and unhealthy anxiety, describing the first as a concern and vigilance which helps people coping with different or difficult situations; the unhealthy anxiety is almost always based on realistic fears such as the concerns about crossing the street at a busy intersection where there are no traffic lights and where there is a realistic chance of being hit by a car. Unlike this, the unhealthy anxiety is an emotional response to threats perceived as real, but which are largely imaginary due to a very low probability of occurrence.(6)

Fears associated with unhealthy anxiety are exaggerated, unrealistic and irrational, such as the fear of riding a roller coaster or flying a plane thinking that it is going to crash. Although it is possible for this to happen, the probability is very small, it is very rare. Ellis points out that "the unhealthy anxiety makes you very often restrict your activities" when you do not need to do this, or it can make you lose control because of the psychosomatic symptoms of panic, phobia, tremors that interfere with the ability to appropriately face the situation.

The overgeneralisations and catastrophizing are the most common examples of cognitive distortions that change the valence of living anxiety towards pathology.

A fascinating aspect of anxiety disorders is the excellent mutual influence of the genetic and experiential factors. There is little doubt that abnormal genes predispose to pathological anxiety state, however, evidence clearly indicates that traumatic life events and stress are also important in terms of etiology. Thus, the study of anxiety disorders presents a

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unique opportunity to understand the relation between nature and the increase in etiology of the mental disorders.(3) Learning and behavioural theories of anxiety postulate that anxiety is a conditioned response to specific environmental stimuli.

In conclusion, anxiety is a normal and positive dimension of human life. It becomes pathological only when it exceeds a certain threshold, defined mainly on the basis of a substantial change in the quality of life. Although the limits of anxiety are still under discussion, eight forms of anxiety disorder have been isolated and will be briefly described below.

The panic attacks (with sudden onset, intense fear or terror, often associated with a feeling of impending death, symptoms such as shortness of breath, palpitations, precordial pain or discomfort, sensations of choking or strangulation and the "fear of going mad" or of losing control).

Agoraphobia (anxiety related to the avoidance of places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of a panic attack or panic-like symptoms.

Panic without agoraphobia is characterized by recurrent panic attacks, unexpected in relation to which there is a persistent concern.

Panic with agoraphobia is characterized both by unexpected panic attacks and by agoraphobia.

Agoraphobia without history of panic (to specify with or without attacks with limited symptoms) is characterized by the presence of agoraphobia and panic related symptoms without a history of sudden panic attacks.

Specific phobia is characterized by a clinically significant anxiety provoked by the exposure to a specific feared object or situation, often leading to the avoidance behaviour.

Social phobia is characterized by a clinically significant anxiety provoked by the exposure to certain types of social or performance situations, often leading to avoidance behaviour.

The Obsessive Compulsive Disorder is characterised by obsessions (which cause a marked anxiety or distress) and or compulsions (which serve to neutralize anxiety).

Post-traumatic stress is characterized by re-experiencing an extremely traumatic event, accompanied by symptoms of increased excitement and avoidance of the stimuli associated with trauma.

Acute Stress Disorder is characterized by symptoms similar to those of the immediate post-traumatic stress as a result of an extremely traumatic event.

The generalized anxiety is characterized by at least 6 months of anxiety, persistent and excessive concerns. Anxiety disorder due to a general medical condition is characterized by prominent anxiety symptoms considered to be the direct physiological consequence of a general medical condition. Substance-induced anxiety disorder is characterized by prominent anxiety symptoms considered to be the physiological consequence of a drug abuse, a medication, or exposure to a toxic.

Anxiety covers a wide range of experiences, much of which are normal and experienced by everyone at some point in life, some of which being even pleasant.

At the pathological extreme, anxiety is unpleasant, disturbing and in its most extreme form, it is one of the most intolerable experiences that the mind and body are exposed to. This range is best depicted in the results of a research made by the American psychologists, 90 years ago. Yerkes and Dodson (4) showed that anxiety has an unusual relation with performance and this relation is best represented by an inverted U, which graphically speaking represents the Gaussian distribution. Thus, the lowest level of anxiety represents the absolute calm, or more precisely described as a deep sleep or as an inactive status and coma. In such a state, there is no response to most of the stimuli and only the most intense of experiences will awake the individual. However, coma is usually an abnormal condition and does not necessarily represent the complete absence of anxiety.

At somewhat higher levels, the person is drowsy, often slipping in and out of sleep and functioning at a very low level. This state is represented by the bottom of the U shape on the left. Anxiety level increases as the basic needs must be met, such as, hunger, thirst, physical and sexual activities. In fact, at these levels, anxiety is an incentive and is extremely important for the protection of species. As strains grow, anxiety increases and is registered as an improvement of performance. However, the activity reaches a plateau where performance cannot be improved, that is the optimal level. Any increase of anxiety above the optimal level can have negative consequences. In case of the optimal level, the person feels tense and under pressure, but it is able to cope with or without a further performance improvement.

Once the anxiety levels rise above this point, performance quickly disintegrates. Concentration deteriorates, the ability to perform complex mental and physical activities is lost and the person does not control anymore the tasks. At the opposite pole, the extreme of anxiety, the person returns to the primitive levels of activity and sometimes he/she must be admitted in a hospital for treatment. This U-shaped graphic can be translated by a person's subjective responses that seem to be the "rises and falls of an anxious man".(4)

It is difficult to decide where first appears anxiety on this spectrum. Obviously, it is not present at the beginning of the curve of U and probably, it occurs when each task increase does not lead anymore to an equal increase in performance and instead, the levels are going down. It is also uncertain from the above-descriptions which are the essential elements of anxiety: is it a feeling or a state of brain, a syndrome or a symptom specific to a catastrophic interpretation of events?

People with anxiety disorders suffer more from the negative consequences as they affect their work and the personal relations, limit their activities and their chances because of their tendency to avoid the difficult situations, preferring to stay in the shade of others than to take action.(1)

The cognitive model of anxiety involves several elements. Anxiety, as an adaptive response to environment, starts with the perception of threat in a specific situation. As it was noted, the meaning that people attach to the situation is determined by their schemes and the memory of their past similar situations. The person then makes an assessment of the seriousness of the threat and an assessment of his/her capacity to deal with it. If the situation is perceived as threatening, a sense of danger will occur. If a threat is perceived as easy, he/she will respond to it as a challenge. The person will feel excitement and enthusiasm. The cognitive and perceptual processes may be affected by the actual mood of the person. In this case, when a person starts to feel anxious, probably he/she will become more vigilant to the perceived threats and will begin to recall the threatening past experiences The person may end up perceiving a threat even where it has never existed before.

When people come across a situation they usually make evaluations. The first is "What is the risk I perceive in this situation?" The second is an assessment of personal and environmental resources that may be available to the individual. If people perceive their resources as appropriate to deal with the risk, they usually will not experience feelings of anxiety.

The cognitive interventions are directed to reduce the perception of threat and to increase self-confidence and the ability to handle the situation.

Prior to intervene, it is however important to assess whether the threat is “perceived or real”, whether the person has or not the capacity to deal with the situation and whether the patient’s perception of the limited resources is true. Rather, symptom patterns vary from person to person.

A person can experience predominantly physical symptoms (eg, tachycardia, shortness of breath, dizziness, indigestion), requiring the development of individualized treatment programme. Anxiety to another person, however, can be characterized by the “fear of what is worst” and thoughts of losing control.

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