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TRAUMA AND ANXIETY DISORDERS THROUGHOUT LIFESPAN: FEAR AND ANXIETY FROM NORMALITY TO DISORDER

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SUMMARY

Anxiety disorders are among the most common mental disorders. Anxiety disorders and neurotic fear cause significant disruption of the psychosocial functioning of the individual. In generalized anxiety disorder, neurotic fear appears in the form of fears, expectations, tension, with nothing specifically uncomprehendingly crying anticipation, worry, poor concentration, psychic and physical fatigue, irritability, restlessness, insomnia, sense of near accident etc.

Traumatic events in the life of the individual are often referred to as potential relevant factors in the occurrence of psychological disorders. Exposure to long-lasting traumatic experiences in childhood leads to the prolongation and fixation of the emotional state of fear and sadness and the emphasized use of certain defense mechanisms that contribute to the structuring of specific clinical images of anxiety states.

Key words: *anxiety - disorders - trauma - childhood*

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INTRODUCTION

Anxiety disorders and fear in general have always kept the attention of the professional, scientific and wider cultural public because man has always lived with fear, a feeling that sustains his constant and prolonged dependence on nature and his own limitations. Fear was proclaimed as a central phenomenon of contemporary society and the existence of humankind in the twentieth century, so we are talking about "years of fear" and "fear as a disease of the century" that threatens to gain epidemic proportions. It is necessary to point out that fear also occurs in normal individuals, where it is useful because it has a warning function (Nastović 1989). The difference between real and non-frightening fear is not as great as it may seem at first glance because there are cases where real fear is much greater than it should be, it has a neurotic upgrade in the phenomenon of fear (Nastović 1989).

Anxiety disorders and neurotic fear cause significant disruption of the psychosocial functioning of the individual. In generalized anxiety disorder, neurotic fear appears in the form of fears, expectations, tension, with nothing specifically uncomprehendingly crying anticipation, worry, poor concentration, psychic and physical fatigue, irritability, restlessness, insomnia, a sense of near accident etc (American psychiatric association 1994, Barlow et al. 1986). In the case of phobia, the intense feeling of fear prevails over the boundaries of the need for the given situation and causes behavior to avoid anxiety provocative situations, and in spite of the criticality of the irrationality and unfounded fear, the individual can not overcome and avoid those well-defined situations (Sadok & Sadok 2012, Stein et al. 1997, Myers & Davis 2007). In panic disorder, recurrent unexpected panic attacks of severe fear are accompanied by somatic and cognitive symptoms that are not conditioned by a dangerous situation or other psychic or somatic disorders or diseases and completely block an individual by preventing adequate social behavior (Bonevski 2008, Massion et al. 1993).

EPIDEMIOLOGY OF ANXIETY DISORDERS

Epidemiological studies suggest that anxiety disorders are among the most common mental disorders. The incidence of anxiety disorders is 14.6-27.8% (Melfsen et al. 2000, Mančevska 2009). The prevalence, however, varies considerably in various surveys from 1.6% to 16% (Faravlelli et al. 2000, Swoboda 2003).

ETHIO-PATHOGENESIS OF ANXIETY DISORDERS

So far, a large number of researches on the origin and nature of fear and anxiety and its various clinical manifestations have been made, and globally we can say that two approaches dominate: biological and psychological.

The *biological approach* points the importance of neurotransmitter systems. In this context, the most prominent are the tests in which importance is given to a range of substances, so called biological correlates, for example the lactate indicated by Pitts and McClear as early as 1967, so yohimbine, carbon dioxide, cholecystokinin, norepinephrine, doxapram, and so on. The increased release of catecholamines and noradrenaline metabolites, the influence of the serotonergic system, and the role of a reduced level of GABA have also been studied. The biological approach also deals with the anatomical

localization of the complex process of occurrence of anxiety and fear that Lebowitz locates in the locus ceruleans and the noradrenergic neurotransmitter system, but the new researches concentrates on the temporal lobe. There are researches of the hypersensitivity of the brain network, so called circles of fear that are the basis for this behavioral and physiological expression, which Le Du and Davis have already worked out well with experimental animals and include the amygdale and its brain projections, the hippocampus and the medial prefrontal cortex (Davis 1992, Le Doux et al. 1990). Neurological studies of Furmark prove that the same circles are also significantly involved in human fear and can be abnormally sensitive in anxiety disorders (Furmark et al. 1997, Gray & McNaughton 2003).

Unlike biological, the *psychological approach* in explaining the phenomenon of anxiety and fear rely exclusively on psychological phenomena. One of the dominant psychological approaches is certainly the psychodynamic model founded by Freud. This model gave many original explanations of the various dimensions of fear that explains how transformed unabsorbed and unused libidinal-sexual energy, without the involvement of other psychological processes. According to this theory of the transformation of libido into fear, this fear occurs when the liberation of sexual energy through orgasm is denied, regardless of whether it is sexual abstinence or the use of coitus interruptus. Translated into the dictionary of current psychiatric literature, the anxiety that originated from overwhelming urgency needs could be called id or impulsive anxiety. In complementing this theory, Freud writes that disabling libidinal discharge is not so much the consequence of external circumstances as the consequence of suppressing unacceptable libidinal demands. In other words, this would mean that when sexual needs are not allowed to be naturally express and meet in a direct way, that energy is suppressed and thus transformed into a neurotic fear (Freud 2008). With the development of psychoanalytic theory and the foundation of the structural theory of personality and Freud's theory of anxiety undergoes significant change. According to this new concept, called signal theory of fear, anxiety is an affect, emotion of the Ego and acts as a signal that warns of an existing internal danger. This danger stems from an intra-psychic conflict between the instincts of the id, the superego's prohibitions, and the demands of the external reality. According to this theory, fear is more cause than the consequence of suppression. Inhibitions and neurotic symptoms develop as measures designed to avoid a hazardous situation (Mančevska 2009). The third Freud theory of fear speaks of separation fear, fear simply explained as a situation in which a loved one is missing, and according to him, this is the basis of fear in general (Bonevski 2008, Fergusson et al. 1996).

Another dominant psychological approach in explaining fear is a behavioral-cognitive approach. The theory of the traumatic conditioning of fear made by Volpe 1958, and then elaborated by Eysenck and Rahman 1965. They define fear as learned emotional reaction, adopted by the conditioning process, while cognitive theories in the center of the fear phenomenon do not put the event itself, but its interpretation which are errors in the cognitive process (Beck et al. 1985, Otaviani & Beck 1987).

TRAUMATIC EXPERIENCES AS PREDICTORS OF ANXIETY DISORDER

Traumatic events in the life of the individual are very often referred as a possible relevant factor in the occurrence of psychological disorders. Charco stated that physical traumatic experiences are possible to cause body seizure. Breuer and Freud essentially supplemented and corrected this perception with the opinion that in the so-called "traumatic neurosis" the real cause is the affect of fear, that often occurs with the trauma and can act more traumatically than the trauma itself. After Nunberg, trauma is called the growth of anxiety which enables the ego to process in a common time unit (Fenichel 1961).

Phenichel believes that the ego has evolved to protect against traumatic conditions, but he also explains that there are stimuli with a very strong intensity that have a traumatic effect on everyone, but there are also other stimuli that are not harmful to most people, and can be traumatic for part of the people who are predisposed to it. Accordingly, what is the degree of excitation that will pass the tolerance of one person depends not only on the strength of the ego, but also on the past experiences, as well as the current circumstances before and during the trauma. Birn points out that the psychological and emotional effect of the traumatic experience on a particular individual is the key moment that determines its pathogenic power (Roy-Byrne et al. 1986).

ABUSE AND NEGLECT IN CHILDHOOD AS A TRAUMATIC DEVELOPMENT FACTOR

Separation from the parents in childhood, caused by divorce or for some other reason is most often emphasized factor associated with the occurrence of mental disorders at adult age (Egami et al. 1996, Nurnberg & Raskin 2000).

Family dysfunction is also a significant factor in the immediate childhood environment found in individuals who developed anxiety disorders (Jumper 1995, Rutter 1987, Torgenson 1986). As traumatic factors that are explicitly indicated in the creation of anxiety in children, are lack of family cohesion, parental care and support, family conflicts and parental criticism, the absence of a close and trusted relationship, warmth and adequate emotional support from parents during the growth (Arrindel et al. 1989, Bruch & Cheek 1995, Luthar 1995).

However, the most traumatic factor that influence emergence of anxiety disorders is violent parental behavior, domestic violence, abuse and, in particular, the overstated protection and over emphasized control and discipline, as well as using shame as a method of disciplining (Bandelow et al. 2004, Caster et al. 1999). Child abuse by many authors, for example, Brown and Briber, is recognized as a significant social problem, leading to higher rates of general psychiatric morbidity in the adult period (Bryer et al. 1987, Margo & McLees 1991) and is associated with mental health disturbance through a complex matrix of behavioral, emotional, social and cognitive factors (Kendall-Tackett 2002).

The term, child abuse, appearing for the first time in 1962, with Kempe's description of the "battered-child syndrome", implies a whole range of experiences, including sexual, physical and psychological harm , abandonment, humiliation, testimony of intra-sexual violence and neglect, and includes physical abuse, sexual abuse, emotional abuse and physical and emotional neglect of children (Garbarino et al. 1980). Epidemiological studies indicate a common appearance of various types of abuse with significant disfunctioning in the adulthood in the physical health, mental health, interpersonal relations and parenthood spheres of (Behl et al. 2003, Bonevski et al. 2001, Leventhal 2003).

Physical neglect is a state of failure to meet the basic needs of the child for physical protection, food, supervision and care for their safety, and emotional neglect is the continuous failure of the parent / guardian to provide the child with adequate support, attention and attachment. In fact, there is no adequate emotional stimulation and support in terms of: empathy, active listening, playing with them, providing incentives, demonstrating satisfaction with the achievements of children and rewarding and respecting the child's personality. *Emotional neglect* is a chronic pattern of behaviors that involves the incitement, insulting of a child's personality and disturbing the emotional development of the child and his sense of worth. *Emotional abuse* as patterns of harmful interactions without the involvement of physical contact with the child is very common form of abuse. Under the influence of this abuse, which is in fact a continuous traumatic relationship, the development of the child is affected in all domains of functioning that are transmitted to the adult age (Glaser 2002). Talking about emotional neglect and abuse, it is important to note that the other extreme, which appears as the opposite of negligence, manifested through over-emphasized care and over-protection, is also significantly detrimental to the personality of the child and his normal psychophysical development.

Physical abuse as any deliberate harm to a child under the age of 18, including hitting, scratching, shaking, burning, tapping, cutting, drowning, choking, etc. can result in bruises, cuts, scratches, burns, fractures and various internal injuries. Physical abuse is rarely a single attack, but as a rule, it is a pattern of behavior that repeats itself through time. It occurs when a parent or other person consciously and deliberately hurts the child, or uses an unreasonable force on him. Over-emphasized discipline and punishment may also fall into this kind of abuse. The consequences of physical abuse are numerous and can be on a

- children's health and physical development;
- on emotional level, the children become frightened, loss confidence in others and loss self-confidence, gain sense of guilt and problems with relationships with others.

The *sexual abuse* is defined as every sexual contact with the child (touching and licking in inappropriate places), sex with the child, bringing in prostitution, showing the intimate parts of the body in front of the children. This type of abuse is particularly traumatic for the child and the consequences, on the one hand, are related to disorders in psycho-sexual development (hypersexual behavior, sexual inhibition), and on the other hand, in non-specific terms are related with serious disorders of psychological maturation.

Researches on the frequency of occurrence in the world, suggests physical abuse ranging from 4.9 to 33.5%, emotional with similar frequency, while sexual abuse is found in 16 to 40% of girls and in 5 to 15% of boys under 18 years of age (Finkelhor et al. 1990). A study conducted in Macedonia in 2000 points to the presence of emotional abuse at 13%, physical abuse at 12%, and sexual abuse in 3% of respondents (Bonevski et al. 2002).

FROM EARLY TRAUMATISATION TO ANXIETY DISORDERS

Of the psychiatric disorders whose occurrence is associated with child abuse, the high correlation with anxiety disorders is highlighted. Numerous epidemiological studies also support the relationship between child abuse and the subsequent development of anxiety disorders (Mancini et al. 1995, Safren et al. 2002, Stein et al. 1996).

Threats from parents in childhood (abandoning and hurting), as a subspecies of emotional abuse, creates a sense of uncertainty as to the availability of the other and consequent uncertainty about their own security and competence for dealing with situations and they lead to development of anxiety symptoms and, development of panic disorder. The experience of separation in childhood, in the predisposed individuals, creates a feeling of endangerment and overflow with fear that gets the characteristics of panic fear. Such an experience can in fact be the prototype or the basis on which further propensity for panic response and development of panic disorder is being built. In fact, it can be said that the panic attack itself is a kind of psychologically regressive behavior in which the adult loses its self-esteem and reliability and shows strong attachment and dependence on the closest or authoritative personalities of the environment (Bonevski 2008).

The overstated protection of parents felt as a burdensome (as another subspecies of emotional abuse) creates a state of deprivation of the usual frustrations through development and disables the normal process of individualization and socialization of the child. In such a state, the individual remains in a position of insecurity towards himself and the outside world, and a predisposition is created for the overstretched reaction of various social stimuli and situations that flood it, and which the individual, with a timeless unfinished process of individualization, perceives as threatening, which is actually a model of the development of social phobic behavior (Bonevski 2008).

Researchers indicate that separation anxiety has phenomenological similarity with the clinical manifestations of panic attack and phobic fear, in explaining the connection of these phenomena (Battaglia et al. 1995, Lipsitz et al. 1994).

The importance of physical abuse, and especially of emotional abuse and neglect in the emergence of anxiety disorders, is undoubtedly important, and can lead to a significant disturbance of child development that has consequences in the adult-life period. Abuse directly reflects the repetitive pattern of the parent-child relationship, which actually turns into a continuous traumatic factor with extremely negative and pathognomonic effect throughout the child's psychological development. In fact, individuals with anxiety disorders have overstretched responsiveness to traumatic conditions, so the traumatic childhood experience emphasizes this existing constitutional factor, responsible for overemphasized responses. They react very complexly to multiple abuse (of many types), which is, as a rule, repetitive over a long period of time from childhood (in the most vulnerable period of psychological development) through a continuum of manifestations to a manifest image of generalized anxiety, phobic fears of various social situations, or panic disorder at adult age. Speaking about the general impact of abuse on the psychological development of children, it should be emphasized that when children are victims of abuse, they develop their own internal defense model with which the world is perceived as a dangerous place for living. Long-standing trauma leads to chronic infirmity that is flagrantly experienced through survivor abuse and leads to further propensity to overestimate the danger and sense of insecurity. This is the matrix in which adults-victims of childhood abuse undermine their sense of self-esteem and self-esteem in coping with both real and presumed dangers. The chronic experience of helplessness, weakness, and endangerment can often be followed up by this. Such distortions in the degree of self-esteem are a steady generator for emotional turbulence and risk of anxiety disorders (Bonevski et al. 2012).

Exposure to long-lasting traumatic experiences in childhood leads to the prolongation and fixation of the emotional state of fear and sadness and the emphasized use of certain defense mechanisms that participate in the structuring of specific clinical images of anxiety states. Thus, in generalized anxiety disorder, the dominant mechanism becomes repression, accompanied by compensation that affects the clinical picture in which anxiety and depression are most pronounced. On the other hand, in the case of panic disorder, except for repression and compensation, the mechanism of defense is also expressed, a regression whose involvement actually leads to panic attacks, which in their essence are psychological regression with complete powerlessness and dependence on the environment, powerful figures and significant psychological fixation with body manifestations. In social phobia, in addition to repression and compensation, the dominant mechanism of defense leads to a modification of the symptoms, that is, the transfer of fear to certain social situations (Bonevski 2008).

PSYCHOTHERAPY IMPLICATIONS

In the therapeutic approach, exposure to conditions that lead to anxiety, panic attacks and social phobia appearances is one of the crucial elements. Facing external and internal triggers should actually spread to the basic causes of anxiety disorders, that is, those that concern the problem of low self-esteem and self-respect, and on which basis the repetitive experience of childhood abuse often lies, as a traumatic situation that carries with it the pattern of anxiety responsiveness to danger, generalized then to a series of real or imaginary hazards that shape the anxiety disorder. The reprobation of early traumatic experiences in a therapeutic situation "here and now" is a fundamental element in the hard process of building self-esteem. The group context in particular demonstrates its usefulness in dealing with early traumatic experiences of abuse whose sharing in a group facilitates their reprocessing. So this study emphasizes the need for early detection of traumatic experiences in childhood and their reprocessing in the psychotherapeutic process in the adult period.

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Contribution of individual authors:

Dimitar Bonevski: analyses and reviewed;
Andromahi Naumovska: literature searches.

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