CHAPTER 24

Anxiety Disorders

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Abstract

Anxiety disorders are the most common group of psychiatric disorders in the general population. They are also important because of their association with significant impairment in functioning and with high direct and indirect costs. Anxiety disorders are often associated with depressive and substance use disorders and may have other complications. These conditions are often unrecognized, misdiagnosed, or trivialized, which is unfortunate because their timely recognition and treatment are beneficial to the sufferers, their families, and society. This chapter provides a brief review of each of the following anxiety disorders in adults: panic disorder, agoraphobia, social anxiety disorder, specific phobia, generalized anxiety disorder, and separation anxiety disorder. Clinical features, diagnostic issues, epidemiological data, etiological factors, and treatments of these disorders are summarized, with the similarities and differences between individual disorders being highlighted.

INTRODUCTION

Anxiety disorders are very common, with the lifetime prevalence in various countries around the world ranging from 9.2% to 28.7%. The best-estimate lifetime prevalence rate for all anxiety disorders was calculated at 16.6%. These conditions are primarily characterized by pathological anxiety, although other emotions, such as disgust, irritability, and shame may also be prominent. Compared to normal anxiety, pathological anxiety is usually experienced as more intense, persistent, and overwhelming, with the person having little or no control over it; also, pathological anxiety often arises in the absence of any real danger or such danger, as perceived by the individual, is grossly exaggerated. Pathological anxiety is associated with significant distress or impairment. Although the diagnostic and classification systems such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) recognize the diagnostic categories of substance/medication-induced anxiety disorder and anxiety disorder due to another medical condition, these are usually not subsumed within the construct of anxiety disorders per se. Likewise, pathological anxiety in the context of schizophrenia, another psychotic disorder or bipolar affective disorder, which is not a part of a specific anxiety disorder, is not considered to denote a distinct anxiety disorder.

According to the DSM-5, anxiety disorders comprise the following conditions: panic disorder, agoraphobia, social anxiety disorder (social phobia), specific phobia, generalized anxiety disorder (GAD), separation anxiety disorder.
disorder, and selective mutism. Given that this chapter focuses on the anxiety disorders in adults, selective mutism will not be reviewed and separation anxiety disorder will be considered insofar as it pertains to adults. Obsessive-compulsive disorder and post-traumatic stress disorder have close relationships with many anxiety disorders, but in the DSM-5 they are classified elsewhere.

### KEY POINTS

- Anxiety disorders are the most common group of psychiatric disorders in the general population and they are associated with significant functional impairment and high direct and indirect costs.
- Anxiety disorders are often unrecognized or misdiagnosed at the primary point of contact with health care providers and are often complicated by depressive or substance use disorders.
- Panic disorder is common in primary care, specialized medical settings, and hospital emergency departments and requires a thorough diagnostic workup to check for the presence of underlying medical conditions.
- Agoraphobia is conceptually independent from panic disorder; when its sufferers become homebound, agoraphobia is incapacitating.
- Social anxiety disorder is arguably the most disabling anxiety disorder, with its frequent complications further contributing to treatment difficulties.
- Specific phobia is a heterogeneous diagnosis; avoidance is the main coping mechanism that often prevents the sufferers from seeking professional help.
- Generalized anxiety disorder has a close relationship with depression and should be better conceptualized so that it could be readily recognized and treated.
- Adult separation anxiety disorder needs to be more clearly delineated from other psychopathology.
- Pharmacological and psychological treatments, especially cognitive-behavioral therapy, have improved the outcomes for anxiety disorders, but there is a need to further refine treatments.

### PANIC DISORDER

The concept of panic disorder includes recurrent panic attacks and the consequent anticipatory anxiety or panic-related behavioral changes. Panic attacks are sudden surges of an intense fear of impending catastrophe, such as dying, losing consciousness and passing out, losing control, or “going crazy.” These episodes are accompanied by bodily symptoms, such as palpitations, chest discomfort or pain, shortness of breath or other respiratory disturbance, dizziness, sweating, trembling or shaking, numbness or tingling sensations, hot or cold flusheds, and/or nausea or abdominal distress. Many of these symptoms reflect hyperarousal of the autonomic nervous system. The peak of a panic attack is reached very quickly, within minutes. While the first panic attack may be experienced as occurring without any reason (“unexpected” or “spontaneous” panic attack), the subsequent panic attacks are usually “situational,” that is, more likely to occur in situations that the person has associated with panic attacks. Panic attacks do not have to lead to panic disorder and may appear in the context of various other mental disorders; in the latter case, they usually denote a more severe form of the disorder and a less favorable course.

Anticipatory anxiety refers to a persistent and often disabling fear of another panic attack. More specifically, the anticipated, though unlikely somatic (heart attack), psychological (loss of control, madness), and/or social (embarrassment, humiliation) consequences of panic attacks are the focus of this fear. Panic-related behavioral changes include avoidance of activities or situations that may precipitate a panic attack (e.g., exercising or crowded places). If this avoidance pertains to agoraphobic situations and becomes prominent and disabling, a diagnosis of agoraphobia may also be considered.

Because of the nature of their symptoms, individuals with panic attacks often present to emergency departments and request urgent help. Bodily symptoms that are a part of the clinical presentation during panic attacks often require a thorough diagnostic workup to check for the presence of an underlying heart disease (e.g., cardiac arrhythmias), neurological condition (e.g., epilepsy), endocrinological disease (e.g., thyroid disease), or other (e.g., pulmonary, vestibular, gastrointestinal) illness.

Table 1 shows epidemiological findings for panic disorder. A striking feature of panic disorder is that it is commonly encountered in primary care, specialized medical settings and hospital emergency departments. Occurrence of the first panic attack after the age of 50 is rare and may suggest “organic” etiology. The course of panic disorder is variable, with at least one third of sufferers reporting a complete recovery and about one half having a chronic, fluctuating course. Common associated conditions are substance misuse and depression. The links between panic disorder and a higher risk of suicide attempts and suicide attempts and cardiovascular disease are not well understood.

A genetic predisposition to developing panic attacks has been proposed, but the nature and specificity of
such predisposition remain unclear. An abnormally sensitive, anxiety-regulating mechanism that originates in the amygdala may be involved in panic disorder and other anxiety disorders. The more specific mechanisms implicated in the pathogenesis of panic attacks include hyperventilation, hypersensitivity to carbon dioxide of the brain-stem chemoreceptors, lower threshold for activating the suffocation alarm mechanism, and failure of the gamma-aminobutyric acid (GABA) system to inhibit the locus coeruleus. With regards to the psychological mechanisms, an exaggerated perception of threat has been proposed to characterize all anxiety disorders. In panic disorder, this threat is perceived to originate within one’s body; other factors that are relatively specific for panic disorder include a heightened anxiety sensitivity (fear of anxiety and its bodily symptoms based on the beliefs about their dangerousness) and misinterpretation of bodily sensations as a sign of an impending catastrophe.

**AGORAPHOBIA**

Agoraphobia shares several features with other phobic disorders: social anxiety disorder and specific phobia (Table 2). It refers to a fear of multiple, interrelated situations that can be grouped into three “clusters.” Situations in the first cluster are those of which the person is afraid because it might be difficult or impossible to immediately escape; they include being in crowded or enclosed places (e.g., shopping centers, cinemas, tunnels) and using public transportation (e.g., buses, trains, planes). The second cluster is represented by situations (e.g., traveling far away from home, staying at home alone) in which the person is alone or outside of their safety zone, so immediate medical or other help might not be available. Situations in the third cluster are those from which it might be awkward or embarrassing to escape immediately (e.g., standing in line, sitting in the middle of a row in a theater).

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**TABLE 1  Epidemiological Data for Anxiety Disorders**

<table>
<thead>
<tr>
<th></th>
<th>Panic disorder</th>
<th>Agoraphobia</th>
<th>Social anxiety disorder</th>
<th>Specific phobia</th>
<th>Generalized anxiety disorder</th>
<th>Adult separation anxiety disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime prevalence (community)</td>
<td>0.4-3.8% Best-estimate: 1.2% Panic attacks: 7.3-28.3%</td>
<td>0.73-10.8% Best-estimate: 3.1%</td>
<td>0.5-16% Best-estimate: 3.6%</td>
<td>0.6-12.5% Best-estimate: 5.3%</td>
<td>1.9-31.1% Best-estimate: 6.2%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Age of onset (in years)</td>
<td>Typical: 20s Mean: 25</td>
<td>Typical: mid-teens to early 20s Mean: 17</td>
<td>Typical: early teens to early 20s Mean: 15-16</td>
<td>Typical: childhood Mean: 10 Animal phobia: early childhood</td>
<td>Typical: late teens to late 20s Can begin at any age</td>
<td>Typical: early childhood Can begin in adulthood</td>
</tr>
<tr>
<td>Demographic correlates</td>
<td>Strong association with</td>
<td>Strong association with</td>
<td>Strong association with</td>
<td>Strong association with</td>
<td>Strong association with</td>
<td>Strong association with</td>
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<tr>
<td></td>
<td>Being separated, divorced, widowed Lower education Urban residence</td>
<td>Work disability</td>
<td>Being single Lower education Unemployment Belonging to lower socio-economic group</td>
<td>Being separated, divorced, widowed Unemployment Belonging to lower socio-economic group</td>
<td>Being unmarried, divorced (?) Lower education (?) Unemployment (?) Work disability (?)</td>
<td>Being unmarried, divorced (?) Lower education (?) Unemployment (?) Work disability (?)</td>
</tr>
</tbody>
</table>
The fear pertains to the known objects, situations, activities, or phenomena (“phobic stimuli”) 
The fear is out of proportion to the actual threat posed by the phobic stimuli and to the sociocultural context 
Insight that the fear is irrational or excessive is usually preserved, but may be absent in children 
Exposure to phobic stimuli elicits an immediate fearful response, sometimes in the form of a panic attack 
Phobic stimuli are avoided or endured with great distress and/or fear if avoidance is not possible 
The fear is persistent and lasts for months and years (minimum 6 months according to the DSM-5) 
The fear or fear-related avoidance causes significant distress or impairment in functioning

These situations are often feared because of the anticipation of panic attacks or symptoms, and the purpose of the subsequent avoidance is to prevent them. This is the reason for the frequent co-occurrence of agoraphobia and panic disorder and for the view that agoraphobia is actually a part of panic disorder. However, in many cases of agoraphobia, the fear is unrelated to panic and sufferers believe that their avoidance is due to fears of falling, being incontinent, getting lost, having an accident, or being mugged. Unlike other phobic disorders, agoraphobia is characterized by reliance on a “phobic companion” (i.e., a person who accompanies the affected individual to a variety of agoraphobic situations so that full-scale avoidance is averted). In the absence of a phobic companion, avoidance is usually extensive and often leads to the person becoming homebound and incapacitated.

Many of the epidemiological findings on agoraphobia (Table 1) are derived from the data on panic disorder with agoraphobia and some may relate more to panic disorder than to agoraphobia. Higher prevalence rates of agoraphobia than those of panic disorder and earlier mean age of onset of agoraphobia than that of panic disorder also suggest the conceptual independence of agoraphobia from panic disorder. It has been consistently reported that agoraphobia is much more likely to occur in women, but remains poorly understood.11,12

Table 1 shows epidemiological data on social anxiety disorder. Many individuals with the condition do not seek professional help because of shame and embarrassment. Those who do seek help often do so after many years and in the context of a complication (e.g., depression) or important life change (e.g., going to a different school or starting a new job). Professional help is usually sought from school counselors, psychologists, or psychotherapists. Social anxiety disorder typically has a chronic course, with significant impairment and disability in many areas of functioning. Depression and substance use disorders, especially alcohol abuse, are frequent complications. The relationship between social anxiety disorder and avoidant personality disorder is important, but remains poorly understood.11,12

There may be a genetic predisposition to social anxiety disorder, but it is likely to be shared with other anxiety and depressive disorders. Behavioral inhibition to the unfamiliar13 represents a predisposition to social anxiety disorder, but also to other anxiety disorders; it refers to the manifestations of inborn temperament observable during early life, which include difficulty sleeping in unfamiliar surroundings, irritability in novel situations...
and avoidance of contacts with unfamiliar people, places, and objects. According to the cognitive models, social anxiety disorder is a consequence of the negative assumptions and beliefs about oneself, others and social situations. These assumptions and beliefs result in appraisals of social situations as threatening and/or perception of the social environment as hostile. Assumptions and beliefs specific for social anxiety disorder and expectations to be evaluated negatively in social situations are maintained through avoidance of social situations, use of safety behaviors and biases in information processing.

SPECIFIC PHOBIA

Specific phobia is a heterogeneous group of conditions that includes phobia of animals, blood-injection-injury phobia (i.e., phobia of the sight of blood, injured tissues, mutilation of the body, or needle penetrating the skin), situational phobia (i.e., phobia of driving or flying, claustrophobia), natural environment phobia (i.e., phobia of water, heights, storms) and other “unclassified” phobias such as dental phobia and phobia of choking or vomiting. The affected individuals are excessively afraid of particular objects, situations, activities, or phenomena (i.e., “phobic stimuli”) because of the perceived threat posed by them. The threat is based on the specific dangers associated with phobic stimuli (e.g., a danger of suffocation while the person is in a small, enclosed place) or disgust. The feeling of disgust is experienced vis-à-vis certain animals, especially insects, and stimuli that serve as reminders of the animal origin and mortality of the humans (i.e., the sight of blood, wounds, or needle penetrating the skin). The blood-injection-injury phobia is a unique type of phobia as it is characterized by a vasovagal reaction, with bradycardia, hypotension, and fainting; unlike all other phobias, it is as common in males as it is in females (Table 1). In all specific phobias, phobic stimuli are avoided as much as possible; if avoidance is not possible, phobic stimuli are endured with much fear or distress (Table 2).

Although specific phobia is common in the community (Table 1), its frequency is lower in the treatment-seeking populations, suggesting that specific phobia may cause less impairment than most other anxiety disorders and/or that individuals with specific phobia are less likely to seek professional help. Indeed, only about 8% of individuals with specific phobia may seek treatment, and most use avoidance as their coping strategy. When they seek professional help, that is usually because changes in their life circumstances prevent them from continuing to avoid their phobic stimuli (e.g., commencing a job that involves frequent travel by plane makes avoidance of flying impossible).

Similar to other anxiety disorders, genetic predisposition to specific phobia is not specific. Many phobias develop as a result of learning. This can occur through a traumatic conditioning (direct aversive experience with the phobic stimulus), vicarious learning (observation of the fear in others) or transmission of the information on the dangerousness of certain objects or situations. Some types of specific phobia (e.g., phobia of heights or water, spider phobia) have been posited to represent “innate” fears, which are not a product of learning; these phobias may have a survival or evolutionary value.

GENERALIZED ANXIETY DISORDER

The main features of GAD are pathological worry and symptoms of tension. Autonomic arousal symptoms may also be present, but they are usually less prominent in GAD than in panic disorder and other anxiety disorders.

Pathological worry relates to several topics or issues, including relationships, family, health, work, or finances, but its cardinal feature is an anxiety-amplifying, uncontrollable cascade of the “what if” pattern of thinking. Pathological worry is largely driven by a difficulty in coming to terms with uncertainty, where worrying could perhaps cease only with an unlikely attainment of complete certainty. The associated doubt prevents a closure, which results in constant anticipation of further problems and no solution in sight. Thus, pathological worrying denotes overthinking that is almost incessant and rather fruitless; as such, it interferes with problem-solving and decision-making.

Tension is usually experienced or expressed as nervousness, feeling “keyed up” or “on edge” or irritability, often with an exaggerated startle response, hypervigilance, restlessness, and inability to relax. Many individuals with GAD complain of muscle tension, which is manifested as muscle tension, stiffness, or pain in the neck, shoulder, or back. Muscle spasms, tic-like movements, jerks, fine tremor, and difficulty swallowing may also be encountered. Largely as a consequence of pathological worry and tension, symptoms of GAD may also include problems with concentration, sleep disturbance, fatigue, and/or exhaustion.

GAD is a chronic disorder closely related to depression. Unlike other anxiety disorders, GAD appears at any age and is prevalent in all age groups. It is also the most frequent anxiety disorder in the elderly. GAD is one of the most common anxiety disorders in the general population (Table 1), but in clinical settings it is usually not seen alone and is often diagnosed as a secondary or co-occurring condition, with the primary or main condition being depression or another anxiety disorder. Individuals with GAD often do not seek professional help; when they do so, they tend to present to general
practitioners with depression or with bodily symptoms, not with pathological worry.19 These patterns of clinical presentation may “mask” GAD and delay recognition and accurate diagnosis.

The similarities between genetic predisposition to GAD and genetic predisposition to major depressive disorder have led to a suggestion that the two conditions are genetically indistinguishable.20 Various neurobiological mechanisms (e.g., hyperactivity of the norepinephrine system, decreased function of the GABA-A receptors) have been postulated to play a role in the pathogenesis of GAD, suggesting that it is a heterogeneous condition; this heterogeneity is also suggested by the effectiveness of the pharmacological agents with various mechanisms of action (Table 3). Psychological models of GAD have focused on pathological worry as the key feature. Thus, it has been postulated that worrying allows a person to avoid unpleasant bodily symptoms that accompany strong emotional states (i.e., that worry serves as “cognitive avoidance”).21 Beliefs about the benefits of worrying (i.e., that worrying can prevent catastrophic outcomes) may maintain worry.22 Intolerance of uncertainty, with an interpretation of ambiguous stimuli and information as threatening, may also play a role in the development of GAD.23 However, intolerance of uncertainty has been found to be a transdiagnostic phenomenon that characterizes several other anxiety disorders as well.24

**ADULT SEPARATION ANXIETY DISORDER**

Separation anxiety disorder in adults is characterized by excessive and persistent anxiety about separation from attachment figures. It is manifested through worries about losing these figures or about possible harm to them with the refusal to go out, travel, or participate in events or activities that entail physical separation; fear of being alone; and recurring nightmares involving separation. The onset of separation anxiety disorder typically occurs in childhood, but the DSM-5 acknowledges that the disorder can also begin in (early) adulthood. It is uncertain whether adult-onset and childhood-onset separation anxiety disorder represent the same condition.

Separation anxiety disorder in adults has much symptom overlap and close relationships with other anxiety disorders (especially agoraphobia and panic disorder), complicated grief, post-traumatic stress disorder, and dependent personality disorder. In clinical practice, other anxiety disorders and depression are diagnosed much more frequently than adult separation anxiety disorder, which has been suggested to be due to a tendency to neglect adult separation anxiety disorder.25 However, it has also been argued that there may be a relatively low clinical need for the diagnosis of separation anxiety disorder in adults, not necessarily its poor recognition, misdiagnosis, or neglect.26 Cultural factors may influence the conceptualization of high levels of separation anxiety as a disorder and in more collectivistic milieus prominent separation anxiety is not necessarily regarded as a disorder.

Considering the diagnostic conundrums, it is not surprising that little is known about epidemiology of adult separation anxiety disorder. While the disorder may be common in the general population (Table 1), further studies need to ascertain its prevalence more precisely, as well as its gender distribution and demographic correlates. Adult separation anxiety disorder can be associated with significant impairment in functioning.

Genetic factors may play a role in the etiology of adult separation anxiety disorder, but the heritability of the disorder has not been estimated. Attachment abnormalities, perception of parents as overprotective, and

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<th>TABLE 3</th>
<th>Evidence-Based Pharmacotherapy for Panic Disorder, Social Anxiety Disorder, and Generalized Anxiety Disorder</th>
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<td><strong>Panic disorder</strong></td>
<td><strong>Social anxiety disorder</strong></td>
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<tr>
<td><strong>First line</strong></td>
<td>• Selective serotonin reuptake inhibitors: sertraline, paroxetine, escitalopram, fluoxetine</td>
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<tr>
<td></td>
<td>• Serotonin and norepinephrine reuptake inhibitors: venlafaxine</td>
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<tr>
<td><strong>Second line</strong></td>
<td>• Tricyclic antidepressants: imipramine, clomipramine</td>
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<td></td>
<td>• Benzodiazepines: clonazepam, alprazolam</td>
</tr>
<tr>
<td><strong>Third line</strong></td>
<td>• Classical, irreversible monoamine oxidase (MAO) inhibitors: phenelzine</td>
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low self-esteem have been associated with adult separation anxiety disorder, but the specificity of these relationships is unlikely. The disorder has been linked with a preoccupied, insecure attachment style in adult relationships. Pathological separation anxiety in children may be a precursor to various anxiety and depressive disorders in adults and does not necessarily continue into adulthood.

**TREATMENT**

The treatment of anxiety disorders aims to decrease anxiety and anxiety-related behaviors (e.g., avoidance), promote better coping with anxiety, decrease vulnerability to anxiety disorders, prevent recurrences and complications, and improve functioning and quality of life. Treatment modalities differ in terms of their ability to address these goals and how they go about reducing the negative impact of anxiety. Of all the treatments used for the anxiety disorders, pharmacotherapy and cognitive-behavioral therapy (CBT) have received most empirical support. Modifications of CBT, such as mindfulness-based therapy and acceptance and commitment therapy, have also demonstrated efficacy. Likewise, controlled studies of psychodynamic psychotherapy for various anxiety disorders have produced favorable results. Pharmacological and psychological treatments are often combined in clinical practice and there is some evidence to support this approach.

**PHARMACOTHERAPY**

Medications are used to alleviate the anxiety symptoms and distress. They do not improve coping with anxiety and are effective only for as long as they are taken. Consequently, relapses following the cessation of pharmacotherapy are not rare. Symptom relief produced by medications is often valued by the sufferers and may facilitate learning of the strategies for effective and long-term coping with anxiety. Pharmacotherapy is usually used for rapid relief of acute anxiety, when the disorder is more severe and in the presence of co-occurring conditions such as depression. The key task in pharmacological treatment is to find the right balance between effectiveness and adverse effects of the medication.

The aim of pharmacotherapy is remission, defined as minimal symptoms and return to normal functioning. Remission promotes recovery and is believed to decrease the risk of relapse after medication discontinuation. In order to achieve remission, medication should be used long enough (usually for at least 6-12 weeks) and in an adequate dose (often the highest recommended dose). If an adequate trial with one medication fails, another medication may be administered or the initial medication is augmented with another pharmacological agent. Maintaining remission entails a continuous, daily use of the medication for at least 6 months. If the remission has lasted for about 6-12 months and the person is ready for medication discontinuation, medication taper can be planned. The duration of this gradual reduction in dose until medication discontinuation depends on the type of medication and personal circumstances. As a rule, medication should not be ceased abruptly after long-term treatment.

Medications used in the treatment of panic disorder, social anxiety disorder, and GAD are listed in Table 3. Pharmacotherapy has not been studied in the treatment of adult separation anxiety disorder and it is considered to be of little value for specific phobia. The role of medication treatment for agoraphobia in the absence of panic attacks or panic disorder is unknown. Selective serotonin reuptake inhibitors and serotonin and norepinephrine reuptake inhibitors are considered by the contemporary treatment guidelines to be the pharmacological treatments of choice. However, these agents are not always effective against the prominent anxiety symptoms, they do not work quickly, and are often associated with adverse effects. For these reasons, benzodiazepines and other medications have been used as alternative or even preferred pharmacotherapy for anxiety disorders, albeit there are some concerns about dependence with benzodiazepines.

**COGNITIVE-BEHAVIORAL THERAPY**

The main advantage of CBT is that it brings about changes in the thinking and behavioral patterns that may reduce vulnerability to the anxiety disorders and decrease the risk of relapse following the cessation of treatment. In addition, CBT fosters an active attitude toward treatment and makes it easier to develop a sense of ownership of treatment gains. For these reasons, therapeutic effects of CBT are more likely to last longer than those of pharmacotherapy.

In clinical practice, cognitive and behavioral therapy approaches are usually combined. They both entail psychoeducation (i.e., a provision of the relevant information and explanation and correction of any misconceptions). CBT for anxiety disorders has been administered in individual and group formats and in recent years it has also been successfully delivered via the Internet. Table 4 lists the specific aspects of CBT and related treatments for the specific anxiety disorders. There are no controlled studies of any psychological treatment, including CBT, in which adult separation anxiety disorder was the specific focus of treatment.

Maladaptive, anxiety-related assumptions, beliefs, misinterpretations, and appraisals, which play a role in
the development and maintenance of anxiety disorders, are targeted by cognitive therapy techniques. These approaches are particularly useful in the treatment of panic disorder, GAD, and social anxiety disorder (Table 4). Behavior therapy aims to change and eliminate behaviors (e.g., avoidance) that help maintain pathological anxiety; with the disappearance of these behaviors, pathological anxiety usually diminishes as well. The key behavioral therapy technique is exposure to situations or stimuli that elicit anxiety; it is most effective for phobic disorders (Table 4) because they are usually characterized by prominent avoidance. Symptom control techniques (e.g., muscle relaxation, breathing retraining) suppress bodily symptoms of anxiety and may be used in conjunction with CBT.

## CONCLUSION

Existing knowledge about anxiety disorders has allowed more precise diagnoses and improvement in treatment outcomes. However, etiological understanding of this realm of psychopathology remains insufficient and calls for further research. Greater insight into the origins and pathogenesis of anxiety disorders is expected to lead to a further refinement of treatment approaches.

## References

REFERENCES


