ANXIETY AND ANXIETY DISORDERS: AN OVERVIEW

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ABSTRACT

Anxiety is the body's natural reaction to stress. It is a sense of fear or fear for what will happen. A work interview or speech on the 1st day of school can make most people feel frightened and nervous. However, if fear is extreme, it takes more than six months, and life interferes, one might have an anxiety disorder. Disorders of anxiety are the most frequent form of the emotional disease and can affect anyone of any age. According to the American Psychiatric Association, women are more likely to be diagnosed with an anxiety disorder than men. One of the most common mental illnesses is a generalized anxiety disorder. Every year, anxiety disorders affect up to 20% of adults. There can be some factors like genetics, brain biology and chemistry, stress, and the environment. There may be different symptoms of the various types of anxiety disorders. However, they all have anxious beliefs or thoughts that are difficult to control. One feels restless, tense, and interferes with everyday life. Over time, they cannot go and get worse. Physical Symptoms, like a heartbeat or a fast heartbeat, aches, pain unexplained, dizziness, or breathlessness. Behavioral changes such as the avoidance of daily activities.

Keywords: Anxiety Disorders, Factors that increase the risk of anxiety disorders, Different Types of Anxiety disorder: Separation Anxiety Disorder, Social Anxiety disorder, Panic Disorder, Generalized anxiety disorder, Agoraphobia, Specific Phobia, Substance/Medication-Induced Anxiety Disorder, Anxiety Disorder Caused by a Medical Condition, Selective mutism, Diagnosis of Anxiety disorder, Treatment of Anxiety disorder.

I. INTRODUCTION

We are all susceptible to anxiety. Anxiety is a normal part of the human experience, but people with anxiety disorders, on the other hand, frequently experience intense, excessive, and persistent worry and fear about daily activities. Anxiety disorders are frequently characterized by repeated episodes of intense anxiety, fear, or terror that peak within minutes. Anxiety disorders include disorders that share excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to a real or perceived imminent threat, whereas anxiety is an anticipation of a future threat. Anxiety disorders are ranked sixth (3.4% of all years lived with disability in 2015). An estimated 264 million people worldwide suffer from anxiety disorders. As a result of population growth and aging, 2015 has increased by 14.9 percent since 2005.

Separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, generalized anxiety disorder, substance/medication-induced anxiety disorder, and anxiety disorder caused by another medical condition are examples of Anxiety disorders. Anxiety disorders are common, and they are a significant cause of disability. Adjusted years of life all over the world. Overall, anxiety disorders impose a significant burden on individual suffering, social impairment, and economic costs.

Prevalence

The current global prevalence of anxiety disorders is 7.3 percent (95 percent CI 4.8–10.9 percent), implying that one in 14 people worldwide has an anxiety disorder at any given time, and one in nine (11.6 percent, 95 percent CI 7.6–17.7 percent) will encounter an anxiety disorder in a given year.

In 2015, an estimated 3.6 percent of the global population suffered from anxiety disorders. Anxiety disorders, like depression, are more common in women than in men (4.6 percent compared to 2.6 percent at the global level). It
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Aspects of physiology and psychology

Correlations and associations between anxiety and various facets of human life – medical or psychological – abound in the research. Anxiety is closely related to a slower rate of health recovery. Anxiety and depression can impact the symptoms of a diabetes condition. Visual acuity has a higher lifetime risk of developing an anxiety disorder. According to research, increased pregnancy-related anxiety may increase Caesarean (C)-section surgical interventions and prolonged labor.

Factors that increase the risk of anxiety disorders

Female gender, family history of Major depressive disorder, a disturbed family environment, childhood, sexual abuse, imperfect self, and low levels of education all significantly increased the risk of all anxiety disorders and major depressive disorder in bivariate analyses. Except for PTSD, the white race increased the risk of all disorders; conduct disorder increased the risk of SAD and specific phobia; and the number of traumas before the age of 21 increased the risk of panic disorder, PTSD, and GAD. Early parental loss increases the likelihood of PTSD while decreasing the likelihood of panic disorder, whereas SUD before the age of 21 reduces SAD, specific phobia, and PTSD.

The Different Types of Anxiety Disorders

1. Separation Anxiety Disorder

Separation anxiety disorder (SAD) accounts for roughly half of all anxiety disorder referrals. Separation Anxiety Disorder is defined as a condition that can last a lifetime but can also begin at any age, resulting in its inclusion among Anxiety Disorders. Even though onset before the age of 18 years is no longer required, the DSM-5 states that it usually begins in childhood and less frequently in adolescence, implying that first onset in adulthood is uncommon and that the majority of children with Separation Anxiety Disorder are considered to be free of impairing anxiety over their lifetime. Separation Anxiety Disorder is defined as "developmentally inappropriate and excessive anxiety about separation from home or those to whom the individual is attached." SAD is distinct from early concerns in that it is characterized by an abnormal response to actual or imagined separation from attachment figures that significantly impair daily activities and developmental tasks. Children and adolescents have a prevalence of 4 to 5%, according to various epidemiological studies.

In contrast to other anxiety disorders, SAD affects 50 to 75 percent of children from low-income families. The severity of symptoms ranges from anticipatory anxiety to full-blown separation anxiety, but children are typically referred to a clinician when SAD causes school refusal or somatic symptoms. School refusal affects approximately 75% of children with SAD, and SAD affects up to 80% of children with school refusal. Longitudinal studies have suggested that childhood SAD may be a risk factor for other anxiety disorders, but whether this link is specific to, say, panic disorder and agoraphobia, or if SAD is a general risk factor for a wide range of anxiety disorders, is still being debated.

2. Social Anxiety disorder

Social Phobia, alternatively referred to as Social Anxiety Disorder. Social phobia involves a "marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to social or performance situations almost always results in an immediate anxiety response, which may include palpitations,
tremors, sweating, gastrointestinal discomfort, diarrhea, muscle tension, blushing, or confusion. In severe cases, may meet the criteria for a panic attack. Common manifestations of People who have social phobia are highly anxious when around other people. They are very self-conscious in front of other people; they are concerned about how they will appear. They are terrified of being embarrassed in front of others. They are terrified that others will judge them. They are concerned for days or weeks before an event where other people will be present. They avoid places where there are other people. Have a difficult time making and keeping friends. When they are around other people, they may experience body symptoms such as blushing, heavy sweating, trembling, nausea, and difficulty speaking.

3. Panic Disorder
Panic disorder (PD) is a common anxiety disorder, with lifetime prevalence rates in the general population ranging from 1.1 percent to 3.7 percent and 3.0 percent to 8.3 percent in clinic settings. While panic attacks are the central feature of PD, patients with posttraumatic stress disorder, social anxiety disorder, and specific phobia also experience panic attacks. However, these typically are not cured by exposure to specific anxiety-causing situations or anticipation in PD. A panic attack can occur at once, but many people usually experience repeated episodes in a longer lifetime. Most people who have ever had a PA have repetitive PA (66.5, s.e. 0.5 percent). Most people recover from panic attacks; only a handful of them develop panic disorder without treatment. The prevalence of lifetime of PAs is 13.2% (s.e. 0.1 percent). The critical feature of a panic attack is a brief period of intense fear or unpleasantness accompanied by at least four of thirteen physical symptoms, such as Palpitations, an increased heart rate, or a pounding heart are all symptoms of a heart condition. Sweating, tremors, or shaking. Sensations of shortness of breath or suffocation, choking sensation, pain or discomfort in the chest, nausea or abdominal pain, unsteadiness, dizziness, lightheadedness, or fainting. De-personalization or derealization. The fear of losing control or going insane. The fear of dying, numbness or tingling sensations are examples of paresthesia. Hot flashes or chills.

4. Generalized anxiety disorder
Generalized anxiety disorder (GAD) is a disorder of excessive worry and anxiety that is not specific to any situation and is thus generalized. GAD has been dubbed the "basic anxiety disorder because the constructs of worry and anxiety underpin many psychological disorders; GAD has been dubbed the "basic anxiety disorder. "GAD has a lifetime prevalence of 5.7 percent and a 12-month prevalence of 3.1 percent; however, studies have found that rates are lower in males, blacks, Asians, and Hispanics than in females, whites, and Native Americans. The average age of onset is in the early to mid-30s, and several studies have revealed that GAD is the most common anxiety disorder among adolescents. GAD is defined by a pattern of recurrent, persistent worry and anxiety out of proportion to the significance of the triggering events. These patients' anxiety levels must be a source of concern. This pattern must occur "more days than not" for at least six months. They have difficulty controlling their worries and exhibit three or more of six somatic or cognitive symptoms, including restlessness, fatigue, muscle tension, or insomnia. Worry is a characteristic of several anxiety disorders: patients with panic disorder worry about panic attacks, while those with OCD worry about their obsessions. Regarding size and scope, the worries that characterize GAD must outnumber the worries that characterize these other anxiety disorders. Children who experience significant and persistent worry can also be diagnosed with GAD; however, unlike adults, they only need to meet one of the six somatic/cognitive symptom criteria.

5. Agoraphobia
Agoraphobia is the fear of being trapped in situations where escape is harrowing or where assistance is unavailable if something goes wrong. While many believe agoraphobia is simply a fear of open spaces, the reality is that it is a more complex condition. According to the National Institute of Mental Health, agoraphobia has a lifetime prevalence of 1.3 percent and an annual incidence rate of 0.9 percent. Males (0.8 percent) and females (0.8 percent) have similar annual prevalence rates of agoraphobia (0.9 percent). Someone who has agoraphobia may be fearful of the following: public transportation leaving the house to visit a shopping center. It is characterized by the fear that these situations will result in a panic attack or panic-like symptoms. As a result, individuals who have agoraphobia make a concerted effort to avoid such situations or locations.

6. Specific Phobia
People who have a specific phobia experience an excessive and unreasonable fear when they are in the presence of or anticipate the presence of a specific object, place, or situation. Expansion is also called the position that
common specific phobias can be grouped as animals, insects, heights, automobiles, air travel, and medical procedures. In contrast to the people living with a specific phobia, those who realize that their fear is irrational to have much trouble ignoring the anxiety they cause. The findings show a 12-month prevalence of specific phobia disorder of about 12% among people over 65. Women were more than twice as likely as men to have a specific phobia disorder, and its prevalence decreased with age in both genders.

7. Substance/Medication-Induced Anxiety Disorder

The name of the substance/medication-induced anxiety disorder starts with the substance (e.g., cocaine, salbutamol) that is thought to be causing the anxiety symptoms. It is unclear how common substance/medication-induced anxiety disorder is. According to general population data, it may be uncommon, with a 12-month prevalence of about 0.002 percent. However, the prevalence is likely to be higher in clinical populations.

8. Anxiety Disorder Caused by a Medical Condition

Clinically significant anxiety that is best explained as a physiological effect of another medical condition is the essential feature of anxiety disorder caused by another medical condition. Symptoms may include severe anxiety or panic attacks. Evidence from the history, physical examination, or laboratory findings must be used to decide that the associated physical condition best explains the symptoms. Furthermore, it must be determined that the symptoms are not better explained by another mental disorder, specifically adjustment disorder with anxiety, in which the stressor is the medical condition. In this case, an individual suffering from adjustment disorder is particularly concerned about the meaning or consequences of the associated medical condition. When another medical condition causes anxiety, there is often a prominent physical component to the anxiety (e.g., shortness of breath). If the anxiety symptoms appear only during delirium, the diagnosis is not made. Anxiety symptoms must cause clinically significant distress or impairment in social, occupational, or other critical areas of functioning. It is unknown how common anxiety disorder is due to another medical condition. Anxiety disorders appear to be more common in people with various medical conditions, including asthma, hypertension, ulcers, and arthritis. However, this increased prevalence could be due to factors other than the anxiety disorder directly causing the medical condition.

9. Selective mutism

Selective mutism is defined by a persistent lack of speech in certain social situations but not others. SM is a relatively uncommon condition that affects one in every 150 children. Most primary schools will have at least one student with SM. It is more common in girls and children from ethnic minority groups and those who have recently migrated from their birth country. Socially awkward, clingy, excessively shy and withdrawn, dreading being expected to speak, serious, stubborn, or aggressive, having temper tantrums when getting home from school, frozen and expressionless during periods when they cannot talk Children with SM may communicate through gestures such as nodding or shaking their heads to convey their message. They may respond with a few words or speak in a different voice, such as a whisper. Some children with SM are also afraid of using public restrooms, possibly because they are afraid of making noises while urinating that others will hear.

Diagnosis of Anxiety disorder

A detailed history and review of symptoms are required to rule out anxiety disorders secondary to general medical or substance abuse conditions. Review the use of caffeine-based drinks (coffee, tea, and colas), over-the-counter medicinal products (caffeine aspirin, sympathomimetic). Enquire the sleeping partner of the patient for apnea episodes or myoclonic wigs. The presence of concurrent depressive symptoms characterizes all anxiety disorders. Severe anxiety disorders can cause agitation, suicide, and increased suicide risk. Always inquire about the idea of suicide or suicide.

Anxiety disorder

Panic disorder patients commonly show to the emergency department with chest pain or dyspnea, fearful of dying of myocardial infarction. They frequently describe an abrupt and sudden occurrence of fear or discomfort, which typically peaks within ten minutes. Panic disorder is defined by the DSM-5 as the experience of recurrent panic attacks, with at least one attack followed by at least one month of fear of another attack or significant maladaptive behavior in response to the attacks. A panic attack is an intense period of fear or discomfort that is accompanied by four or more of the following thirteen systemic symptoms:
• Palpitations, a pounding heart, or an accelerated heart rate are all symptoms of an accelerated heart rate,

• Excessive sweating, trembling, or shaking

• Breathlessness or a sensation of suffocation, Choking sensations, Pain or discomfort in the chest, nauseous or abdominal discomfort, If one experiences dizziness, unsteadiness, lightheadedness, or fainting, Chills or sensations of heat, Anesthetics, Depersonalization, Fear of succumbing to insanity or going insane, Fear of death.

• Patients experience an overwhelming desire to flee or escape and a sense of impending doom during the episode. Additionally, headaches, cold hands, diarrhea, insomnia, exhaustion, intrusive thoughts, and ruminations may occur.

• Patients with panic disorder experience recurrent panic attacks, with fear of recurrence resulting in significant behavioral changes (e.g., avoidance of situations or locations) and concern about the attack's implications or effects (e.g., losing control, going crazy, dying).

• Panic disorder can cause personality changes, such as the patient becoming ever more passive, reliant, or withdrawn.

Determine precipitating events, suicidal ideation or intention, phobias, agoraphobia, and obsessive-compulsive behavior. Exclude alcohol, illicit drugs (e.g., cocaine, amphetamine, phencyclidine, amyl nitrate, lysergic acid diethylamide [LSD], yohimbine, 3, 4-methylenedioxymethamphetamine [MDMA, or ecstasy]), cannabis, and medications from consideration (e.g., caffeine, theophylline, sympathomimetics, anticholinergics).

Consider the symptoms of other medical conditions that
May include anxiety as a primary symptom, Angina and myocardial infarction (e.g., dyspnea, chest pain, palpitations, diaphoresis), Cardiac dysrhythmias (e.g., palpitations, dyspnea, syncope), Mitral valve prolapse, Pulmonary embolus (e.g., dyspnea, hyperpnea, chest pain), asthma (e.g., dyspnea (e.g., palpitations, diaphoresis, tachycardia, heat intolerance), Hypoglycemia, Pheochromocytoma (headache, diaphoresis, hypertension), Hyperparathyroidism (muscle cramps, paresthesias), Transient ischemic attacks (TIAs), and Seizure disorders.

Generalized anxiety disorder
• Excessive anxiety and worry about various events and activities characterize this disorder. Controlling worry is difficult. Anxiety and worry are associated with the occurrence of at least three of the following six symptoms on a more frequent than not basis for at least six months:

• Restlessness or a heightened state of alertness or apprehension,

• Being quickly exhausted, having difficulty concentrating or going blank in mind, irritability

• Tension in the muscles

• Sleep deprivation.

While suicidal ideation and attempted suicide are not diagnostic features, they have been linked to generalized anxiety disorder.

Social anxiety disorder
A person who has social phobia will typically report a solid and persistent fear of social or performance circumstances in which he or she may be scrutinized by others, to the point of impairing his or her ability to function at work or school. The individual fears that they will exhibit anxiety symptoms, resulting in humiliation or embarrassment. Exposure to social or performance situations almost always results in fear or anxiety. These conditions are either prevented or endured with excellent trepidation avoidance behavior, anticipation, or distress in the feared social or performance setting results in significant functional impairment.
Inquire about any social difficulties the patient may have, such as speaking in public, eating in a restaurant, or using public restrooms. People with social phobia frequently describe their fear of being scrutinized by others or embarrassed or humiliated.

Agoraphobia

Inquire about any severe anxiety reactions the patient has when confronted with specific situations, such as heights, animals, small spaces, or storms. Other areas of investigation should include the fear of being trapped with no way out (e.g., being outside the home and alone; in a crowd of unfamiliar people; on a bridge, in a tunnel, in a moving vehicle).

Specific phobia

If specific phobias are suspected, specific questions about unreasonable and out-of-proportion fear of specific situations must be asked (e.g., animals, insects, blood, needles, flying, heights). Phobias can be incapacitating and cause significant emotional distress, leading to other anxiety disorders, depression, suicidal ideation, and substance-related disorders, particularly alcohol abuse or dependence. The doctor should also inquire about these issues.

MSE (Mental Status Examination)

Each patient with anxiety symptoms should undergo a comprehensive mental status examination, which will assess their appearance, behavior, ability to cooperate with the exam, activity level, speech, mood and affect, thought processes and content, insight, and judgment. Physical symptoms of anxiety include sweaty hands, restlessness, and distractibility. Effects are usually oriented and cooperative times three. Normal or depressed moods are possible. Affect is frequently preserved. Psychotic symptoms are not common in simple anxiety disorders. Suicidal ideation should be assessed by inquiring about passive thoughts of death, desires to die, and thoughts of harming oneself, or plans or acts of self-harm. Homicidal ideation is rare. Cognition is usually normal, with no memory, language, or speech problems. In most cases, insight and judgment are intact.

Generalized anxiety disorder

Two main mental status examinations should be assessed in generalized anxiety disorder. The first involves asking about suicidal/homicidal ideation or plan, such as the following:

Have you ever wished you were never born, thought you would be better off dead, wish to harm yourself or others, have a plan to harm yourself or others, or ever tried to kill yourself or seriously injure yourself or others?

- The second involves formal testing of orientation/recall, such as the following:
  - Does the patient respond when called by name (oriented to person)?
  - Is the patient-oriented to place and time? When asked what place, season, day, month, the year it is, does the patient respond appropriately?
  - Does the patient have an intact short- or long-term recall? Ask the patient to spell the word WORLD forward and backward, count backward from 100 by 7s, recall what he or she did to celebrate his or her birthday last year and the name of his or her first-grade teacher.

Panic disorder

In order to make a diagnosis, it is necessary to conduct a mental status examination. The Primary Care Evaluation of Mental Disorders (PRIME-MD), the Mobility Inventory for Agoraphobia (MIA), the Agoraphobia Cognitions Questionnaire (ACA), and the Body Sensations Questionnaire are all standardized assessments (BSQ).

There are no apparent symptoms of panic disorder on a mental status test. Although the patient may or may not seem nervous at the time of the interview, their Mini-Mental Status Examination, which includes cognitive
performance, memory, serial-7, and proverb interpretation, should be in good working order and compatible with the patient's educational level and apparent baseline intellectual functioning.

Although an anxious-appearing individual will be revealed during the mental status test, this is unnecessary for diagnosis. The speech may reflect fear or urgency, or it may sound natural. The mood is similar to that of "anxious," with a similar effect. Other diagnostic possibilities should be considered if an incongruent effect is present. Thought processes should be rational, sequential, and oriented toward a specific objective. It is essential to analyze thinking content to ensure a patient does not have suicidal or homicidal thoughts. As a type of acute mental anguish, acute anxiety can lead to risky or self-destructive actions. Other etiologies should be considered if there are abnormalities in the thought process or thought substance (aside from impulsive suicidal thoughts). In most cases, insight and judgment are present and intact.

**Phobic disorders**

When a patient is confronted directly with the object of his or her phobia, the patient's mental status examination is significant for the presence of an anxious affect with a limited range. There may be neurovegetative symptoms present (such as tremor or diaphoresis). Additionally, the patient expresses anxiety (mood) and can articulate the source of his/her anxiety (thought content). The thought content is critical for phobic ideation (unrealistic and out-of-proportion fears). While insight may be impaired, particularly during exposure, the patient typically retains insight, and while they report being unable to control their feelings, they also recognize that the severity of their fears is unjustified.

At other times, a patient with the phobic disorder has a normal mental state, except thought content indicative of phobic ideation. Notably, phobic ideas may remain hidden unless specific questions about phobias are asked. While phobias do not manifest with suicidal or homicidal ideation, comorbid conditions such as depression and other anxiety disorders do. If there are co-occurring conditions, a separate assessment of suicidal and homicidal risk should be conducted.

**Physical examination**

Since anxiety can present with a range of physical symptoms, any patient that presents with a de novo complaint of physical clinical signs of an anxiety disorder should undergo a physical examination and a basic laboratory workup to rule out other medical conditions that can present with anxiety-like symptoms.

When a patient returns for a repeat visit with similar complaints after medical causes have been ruled out, a careful mental status examination may be more appropriate than a repeat physical examination and laboratory tests. While considering anxiety as the primary suspect, the physician should keep in mind that patients who suffer from anxiety develop medical conditions at the same rate as other patients over time. In other words, a diagnosis of anxiety should not obviate the patient from routine follow-up examinations unless otherwise indicated.

**Anxiety disorder**

No physical examination findings are diagnostic of panic disorder. The history is used to make the diagnosis.

The patient may appear anxious. When a patient presents in an acute state of panic, he or she may physically exhibit any of the anticipated signs of an elevated sympathetic state. Tachycardia and tachypnea are common; blood pressure and temperature may be expected, though hypertension may also occur. There may be tremors. It is possible to observe cool, clammy skin. By observing breathing, hyperventilation may be challenging to detect because the respiratory rate and tidal volume may appear normal. Patients may exhibit frequent sighs or have difficulty holding their breath. Over breathing does not reliably reproduce symptoms. There may be a Chvostek sign, a Trousseau sign, or an overt carpopedal spasm present.

The remainder of the examination findings is usually consistent with panic disorder. However, keep in mind that panic disorder is primarily an exclusion diagnosis, and attention should be paid to excluding other disorders.
A panic attack typically lasts between 20 and 30 minutes from the time it begins—rarely more than an hour. During an attack, patients' primary focus may be on somatic concerns about death from cardiac or respiratory problems. Patients may present to the emergency department.

**Anxiety disorder with widespread manifestations**

Tremor, tachycardia, tachypnea, sweaty palms, and restlessness are all common physical symptoms of generalized anxiety disorder. Children and adults with generalized anxiety disorder commonly experience unpleasant physical symptoms such as rapid heartbeat, shortness of breath, increased sweating, stomach cramping, a lump in the throat or inability to swallow, frequent need to urinate, dry mouth, nausea, diarrhea, cold and/or clammy hands, headaches, or neck or backaches. Nervous tension is frequently accompanied by shaking, trembling, twitching, or body aches. Children, in particular, are frequently misdiagnosed or receive incorrect treatment, and they may be subjected to unneeded, invasive, or hazardous medical testing and improper medication treatment for the alleged presence of physical illnesses, resulting in an increase in the intensity of their fear and anxiety about their health status.

**Treatments for Anxiety Disorder**

Numerous treatments are available to help reduce and manage the symptoms of an anxiety disorder. People suffering from anxiety disorders typically take medication and seek counseling.

Anxiety disorder treatments include:

Medication is required. Anxiety disorders are treated with a variety of medications.

Antidepressants are medications used to treat depression. Modern antidepressants (SSRIs and SNRIs) are usually the first medications prescribed to someone suffering from an anxiety disorder. SSRIs include escitalopram (Lexapro) and fluoxetine (Prozac). Duloxetine (Cymbalta) and venlafaxine are examples of SNRIs (Effexor).

Bupropion is a type of medication. Another type of antidepressant that is commonly used to treat chronic anxiety. It differs from SSRIs and SNRIs in their mechanism of action.

Antidepressants that are not SSRIs. Tricyclics and monoamine oxidase inhibitors are examples of these (MAOIs). They are less commonly used because of side effects such as blood pressure drops, dry mouth, blurry vision, and urinary retention can be unpleasant or dangerous for some people.

Benzodiazepines are sedatives. If a patient is experiencing persistent panic attacks or anxiety, the doctor may prescribe one of these medications. They aid in the reduction of anxiety. Alprazolam (Xanax) and clonazepam are two examples (Klonopin). They work quickly, but they can become addictive. They are typically used as an adjunct to anxiety disorder treatment and should not be used for an extended period.

Beta-blockers are medications that prevent the body from producing insulin. If one has physical symptoms of anxiety, such as a racing heart, trembling, or shaking, this type of high blood pressure medication may help them feel better. During an acute anxiety attack, a beta-blocker may help to relax.

Anticonvulsants are medications that are used to treat seizures. These drugs, which are used to prevent seizures in people with epilepsy, can also relieve specific symptoms of anxiety disorders.

Antipsychotic medications. Low doses of these drugs can improve the efficacy of other treatments.

Buspirone is a drug used to treat addiction (BuSpar). This anti-anxiety medication is occasionally used to treat chronic anxiety. It is necessary to take it for a few weeks before experiencing complete symptom relief.

Psychotherapy is a type of counseling that teaches about the impact of emotions on behaviors. It is occasionally referred to as talk therapy.

Cognitive-behavioral therapy (CBT): This widely used form of
Psychotherapy teaches patients how to transform negative or panic-inducing thoughts and behaviors into more positive ones.

II. SUMMARY

Anxiety disorders are ranked sixth (3.4% of all years lived with disability in 2015). An estimated 264 million people worldwide suffer from anxiety disorders. Fear is an emotional response to a real or perceived imminent threat, whereas anxiety is the anticipation of a future threat. Separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, and generalized anxiety disorder are examples of Anxiety disorders. Overall, anxiety disorders impose a significant burden on individual suffering, social impairment, and economic costs. The current global prevalence of anxiety disorders is 7.3 percent (95 percent CI 4.8–10.9 percent). Anxiety disorders, like depression, are more common in women than in men. It is estimated that 7.7 percent of the female population in the Americas suffers from anxiety disorder (males, 3.6 percent). Prevalence rates do not differ significantly by age group, though there is a lower prevalence among older age groups. There are several types of anxiety disorders. Using certain medications or illegal drugs or withdrawal from certain drugs can trigger some symptoms. Social anxiety disorder feels overwhelming worry and self-consciousness about everyday social situations. Separation anxiety is the fear that something terrible may happen to a loved one. Medication-induced anxiety disorder can trigger symptoms of anxiety disorder.

Anxiety disorders can make it hard to breathe, sleep, stay still, and concentrate. The main symptom of anxiety disorders is excessive fear or worry. Common symptoms are panic, fear, uneasiness, and a feeling of doom or danger. Specific symptoms depend on the type of anxiety disorder one has. Several types of drugs are used to treat anxiety disorders. Antidepressants are typically the first drugs prescribed to someone with an anxiety disorder. Beta-blockers can help one feel better if one has physical symptoms of anxiety. Cognitive-behavioral therapy (CBT) teaches how to turn negative, or panic-causing, thoughts and behaviors into positive ones. Psychotherapy helps learn how emotions affect behaviors. Talk therapy is a type of counseling that helps understand emotions and behaviors. Some places offer family CBT sessions to help families cope with panic attacks and other anxiety-related symptoms.

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