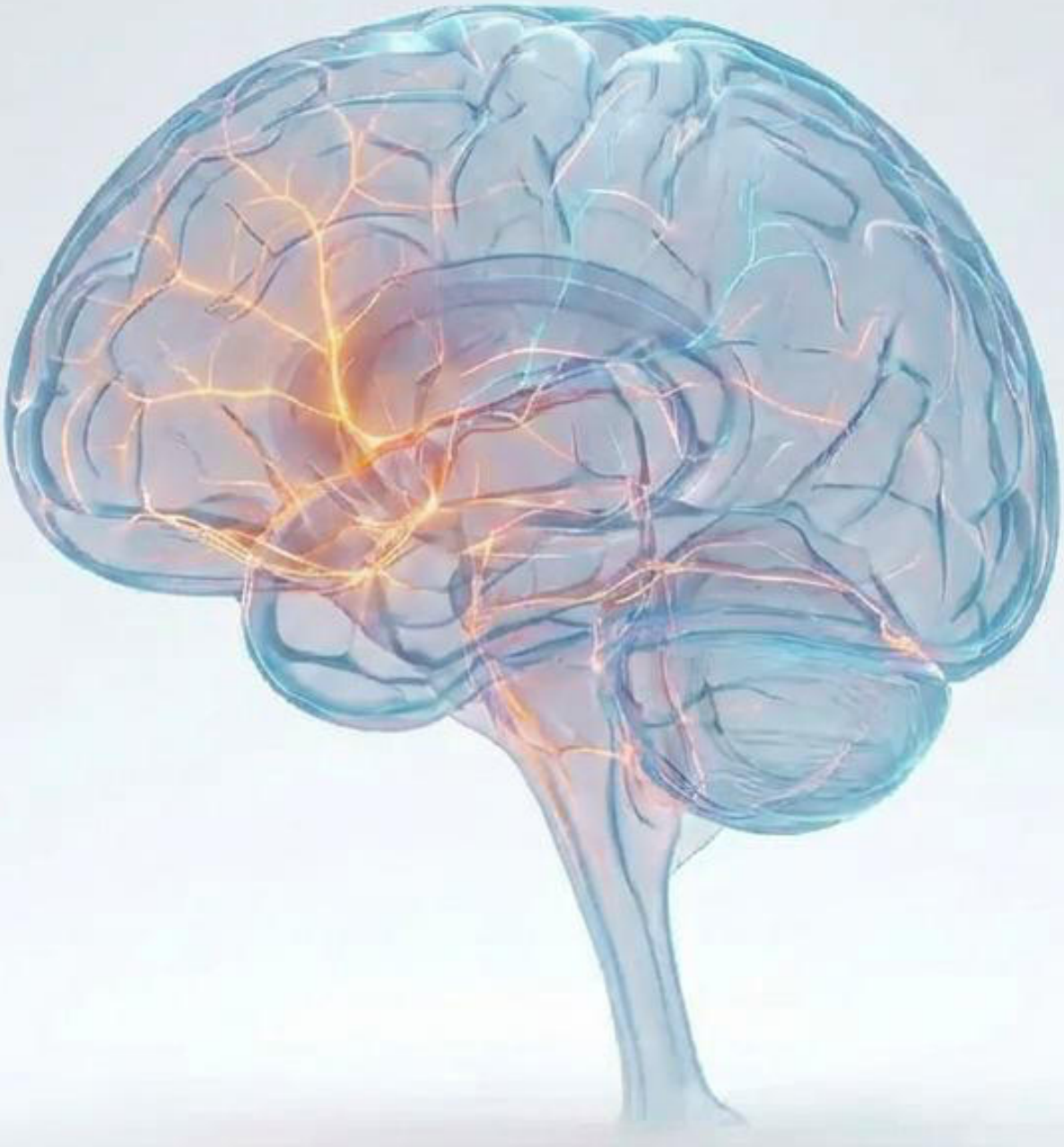
ACUTE ANXIETY

National Standard Treatment Guideline



Ministry of Health
Republic of Maldives

ADB

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Japan Fund for Prosperous and Resilient Asia and the Pacific

From the People of Japan

World Health Organization
Maldives

National Standard Treatment Guidelines

- Acid Peptic Disease
- Acute Anxiety
- Acute Pancreatitis
- Acute Psychosis
- Acute kidney Injury
- Arrhythmia
- Chronic Liver Disease
- Chronic Pancreatitis
- Chronic kidney disease
- Congenital Heart Diseases
- Dementia
- Depression
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Gestational Diabetes
- Epilepsy
- Heart Failure
- Hyponatremia
- Hypernatremia
- Hypokalemia
- Hyperkalemia
- Interstitial Lung Disease
- Liver Failure
- Obesity
- Obstructive Sleep Apnoea
- Osteoarthritis
- Ovarian Cancer
- Pneumonia
- Stroke
- Upper Gastrointestinal bleed
- Unstable Angina

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GUIDELINES DEVELOPMENT METHODOLOGY

The development of the Maldives Standard Treatment Guidelines (STGs) followed a structured, evidence-informed, and consensus-driven methodology adapted from internationally accepted guideline-development standards and the Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) model. The process combined systematic evidence retrieval, critical appraisal, contextual adaptation, and multidisciplinary expert review to ensure feasibility, clinical relevance, and national ownership.

1. Determining Scope and Priority Conditions

Priority clinical conditions were identified through consultation with national programme managers, specialty clinicians, and health-system stakeholders. Selection criteria included: (i) major causes of morbidity and mortality, (ii) observed variation in clinical practice or prescribing patterns, (iii) potential to improve patient outcomes, and (iv) the feasibility of implementation across health-facility levels in Maldives. The final list of diseases reflected national epidemiology, service-delivery capacity, and essential-medicine availability.

2. Identification of Existing Evidence and Source Guidelines

A targeted search strategy was used to identify high-quality existing clinical guidelines. Searches were conducted across international guideline repositories (e.g., WHO, NICE, SIGN and other intergovernmental bodies, international and national guideline repositories, specialty societies and professional associations.

3. Quality Appraisal of Source Guidelines

Retrieved guidelines were screened for transparency of development, methodological rigour, clarity of recommendations, applicability to health-system reality, editorial independence. Guidelines were included if they met the Institute of Medicine (IOM) definition of a clinical guideline and addressed treatment or management of priority conditions. Guidelines that did not meet minimum quality standards, review articles, diagnostic criteria, or technical standards were excluded.

4. Adoption, Adaptation, and Contextualization

The guideline-development team employed an adopt–adapt–contextualize model:

- **Adoption**: High-quality recommendations that aligned with Maldivian health-system realities were retained without modification.
- **Adaptation**: Recommendations were modified when local considerations such as diagnostic capacity, medicine availability, workforce skills, referral pathways, or cost constraints affected feasibility.

- **Contextualization**: Where evidence was absent or inconclusive, conditional recommendations were formulated based on expert consensus, with explicit consideration of pragmatism, safety, and local workflows.
  Medicines were selected in alignment with the Maldives National Essential Medicines List (NEML), based on suitability, efficacy, safety, and availability.

5. Expert Consensus and Multidisciplinary Input

Draft recommendations were initially prepared by experts from the DSPRUD, India, providing a strong methodological foundation for the process. Building on this, a collaborative and participatory process brought together clinicians from internal medicine, paediatrics, obstetrics-gynaecology, surgery, emergency medicine, endocrinology, cardiology, general practitioners, and public health representing different levels of healthcare. Consensus was achieved through moderated discussions, iterative revisions, and resolution of divergent views. For topics lacking strong evidence, recommendations were derived from expert clinical judgment grounded in extensive practice experience.

6. Drafting, Peer Review, and Validation

Each guideline section was organized in a standard format including key clinical features, essential investigations, non-pharmacological management, pharmacological therapy (with step-up/step-down options where relevant), referral criteria, paediatric considerations, and follow-up requirements. Drafts were peer-reviewed by senior clinicians and national experts. Reviewer comments were systematically integrated to strengthen clarity, accuracy, and applicability.

7. Addressing Conflicts of Interest

All contributors declared the absence of conflicts of interest. Individuals with potential or perceived conflicts were excluded from authorship or decision-making roles.

8. Updating and Future Revisions

The STGs were conceptualized as a living document. Future updates will incorporate new scientific evidence, changes in essential-medicine availability, national programme priorities, and user feedback from clinicians. Periodic review cycles will ensure the continued relevance and reliability of recommendations.

9. Distinctive Features of the Guidelines

Developed through a collaborative process involving a large group of multidisciplinary experts from different levels of healthcare, the guidelines incorporate the following distinctive features:

- **Diagnostic Assumption and Confirmation**: While assuming that an initial diagnosis has been established by the healthcare provider, the guidelines provide essential information for confirming diagnoses. This includes a comprehensive overview of major signs and symptoms, descriptions of confirmatory tests, and clear guidance on practices that are prohibited, discouraged, or unreliable—promoting evidence-based medicine supported by relevant references.
- **Comprehensive Treatment Approach**: The guidelines offer a systematic, up-to-date framework for managing medical conditions across the continuum of care. They begin at the primary care level and extend to secondary and tertiary care, incorporating protocols for treatment response assessment and referral criteria as integral components.
- **Diverse Treatment Modalities**: Recommendations encompass both non-pharmacological and pharmacological interventions and surgical intervention where applicable, providing flexibility for individualized treatment plans. Cautionary notes are included where necessary to ensure safe and effective use of therapies.
- **Assessment and Referral Criteria**: Clear criteria and goals for evaluating patient response to treatment are provided, along with guidance on when referral to higher levels of care is warranted ensuring continuity and comprehensiveness in patient management.

ACKNOWLEDGEMENTS

The Government of the Republic of Maldives is committed to ensuring universal access to quality health services for all citizens. The Constitution of Maldives mandates the progressive realization of rights, including the right to good standards of health care for the population. In line with this national commitment, standardized quality health services are regarded as the foundation of a strong and equitable healthcare system.

This important work would not have been possible without the cooperation and support of many individuals and institutions. We express our sincere appreciation to the Honourable Minister of Health, Abdullah Nazim Ibrahim, for his leadership, commitment, and continuous guidance throughout the development process. We are grateful to WHO and ADB for their significant contribution, support, and technical assistance.

Our heartfelt gratitude is extended to the technical lead and editor, Dr. Sangeeta Sharma, Professor, Neuropsychopharmacology, IHBAS and President, Delhi Society for Promotion of Rational Use of Drugs (DSPRUD), and her team. We express our deepest appreciation to the Maldivian and DSPRUD experts and contributors who played a pivotal role in this process. Their technical expertise and dedication to adapt the standards to the Maldivian context have been instrumental in the development and finalization of these guidelines. The time, experience, generous sharing of knowledge and insights contributed by all parties have not only enriched the work but also have been invaluable in making these standards practical, locally acceptable, and aligned with the needs of the resident population.

It is important to acknowledge the immense efforts, involvement, timely coordination, collaboration, and dedication of the Quality Assurance and Regulation Division team who made it possible for these Clinical Treatment Guidelines to come into existence.

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ACUTE ANXIETY

ANXIETY DISORDERS

QUICK REFERENCE GUIDE

Anxiety disorders are among the most common mental health conditions worldwide. These disorders typically begin in adolescence or early adulthood, but prevalence can reach up to 10% in children and 11% in older adults.

Definitions & different types

- **Anxiety disorders:** Conditions with excessive, persistent fear/worry causing distress or functional impairment.
- **Types of anxiety:** Generalized anxiety disorder (GAD), panic disorder, social anxiety disorder (social phobia), specific phobias, agoraphobia, separation anxiety disorder (adult).

Causes, risk factors & triggers

- **Biological:** Genetic vulnerability; neurotransmitter dysregulation (serotonin, gamma-aminobutyric acid [GABA], noradrenaline).
- **Psychological:** Maladaptive coping, perfectionism, trauma.
- **Social:** Chronic stress, isolation, financial hardship, unstable housing.
- **Common triggers:** Health scares, bereavement, relationship/ occupational stress, chronic illness, substances (caffeine/stimulants), alcohol/benzodiazepine withdrawal.

Evaluation for diagnosis

- Clinical features (history): Onset/ duration/pattern; precipitating factors; avoidance; impact at work/ home/sleep; safety (suicidality).
- Physical examination: Vitals; thyroid/ eye signs; cardiopulmonary and brief neurologic screen.
- Laboratory/ancillary tests (as indicated): Thyroid function, complete blood count (CBC), fasting glucose, electrolytes; electrocardiogram (ECG) if palpitations; vitamin B12/folate when deficiency risk.
- Screening/severity tools: Generalized Anxiety Disorder-7 (GAD-7), Hospital Anxiety and Depression Scale-Anxiety (HADS-A), Panic Disorder Severity Scale (PDSS), Liebowitz Social Anxiety Scale (LSAS).
- Confirmation: Symptoms meet Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)/International Classification of Diseases, 11th revision (ICD-11) criteria; functional impairment present; medical/substance (caffeine, alcohol, stimulants, benzodiazepine withdrawal) causes excluded. Refer to psychiatry/clinical psychology if atypical, severe, or treatment resistant.

Classification / severity assessment

- By type (as above) and severity (mild/ moderate/severe) using: symptom intensity/frequency, functional ...

impairment, autonomic signs, and risk factors (depression, substance use, suicidality). Reassess regularly; severity fluctuates.

Differential diagnosis

- **Psychiatric:** Depression, adjustment disorder, somatic symptom disorder, OCD, PTSD.
- **Medical:** Hyperthyroidism, arrhythmias, asthma/COPD, seizure disorders, pheochromocytoma, anemia.
- **Substances/medications:** Caffeine/stimulants, alcohol/benzodiazepine withdrawal, bronchodilators, steroids, thyroid meds.
- **Normal stress response:** Proportionate, short-lived anxiety to a clear stressor without functional impairment.

Management goals & principles

- **Goals:** Reduce symptoms, restore function, prevent relapses, improve quality of life.
- **Principles:** Psychoeducation; first-line psychotherapy; first-line pharmacotherapy when indicated; monitor response/side effects; treat comorbidities; plan relapse prevention; shared decision-making.

Approach to management

- **GAD:** Cognitive behavioral therapy (CBT); selective serotonin reuptake inhibitor (SSRI)/serotonin– ... norepinephrine reuptake inhibitor (SNRI); continue meds 6–12 months after remission.
- **Panic disorder:** Psychoeducation; CBT with interoceptive/situational exposure; SSRI/SNRI; benzodiazepine short-term only if severe distress while initiating antidepressant.
- **Social anxiety disorder:** CBT with social skills and graded exposure; SSRI (or SNRI) if moderate–severe; propranolol as-needed for performance-only subtype.
- **Specific phobias:** Exposure-based therapy is primary; meds rarely needed.
- **Agoraphobia:** CBT with gradual exposure; SSRI/SNRI if marked impairment or comorbidity.
- **Separation anxiety (adult):** CBT targeting attachment/safety behaviors; SSRI if persistent.

Non-pharmacological interventions

- **Psychoeducation;** self-help workbooks/apps; relaxation and diaphragmatic breathing; mindfulness-based programs; problem-solving therapy; graded exposure plans; sleep/exercise routines; limit caffeine/alcohol/nicotine.
- **Low-resource setting:** Task-sharing with trained primary-care teams; group formats; telepsychiatry; brief manualized CBT elements; use GAD-7/PHQ-9 to track; standardized taper/bridging protocols.

PHARMACOLOGICAL THERAPY

Drug (class)	Primary use	Start → Titrate	Usual/Max daily dose	Route	Duration guidance	Key cautions
Fluoxetine (SSRI)	GAD/panic/ social anxiety	10–20 mg → ↑ by 10–20 mg q2–4 wks	20–60 mg (max 60 for anxiety)	PO OD (AM)	6–12 months after remission	Long half-life; strong CYP2D6 inhibitor; insomnia; initial anxiety activation, GI upset
Escitalopram (SSRI)	GAD, panic, social anxiety	5–10 mg → ↑ by 5–10 mg q2 wks	10–20 mg (max 20)	PO OD	6–12 months after remission	QT caution at high dose; sexual dysfunction; hyponaetremia (elderly)
Venlafaxine XR (SNRI)	GAD, social anxiety, panic	37.5–75 mg → ↑ by 37.5–75 mg q1–2 wks	75–225 mg (max 225)	PO OD	6–12 months after remission	BP rise; withdrawal if abrupt stop; insomnia, GI upset
Buspirone (anxiolytic)	GAD adjunct/ mono	7.5–10 mg BID → ↑ by 5 mg/ day q2–3 days	20–30 mg usual; max 60 mg	PO BID–TID	4–6 wks to full effect; long-term ok	Dizziness; no sedation/ dependence; onset delayed
Propranolol as adjunct	Performa nce anxiety (somatic)	10–40 mg PRN 30–60 min pre-event	10–40 mg PRN; or 10–20 mg TID short course	PO	PRN/short	Avoid in asthma/bradycardia; masks hypoglycemia; fatigue, depression in some patients
Clonazepam	Bridge for severe panic	0.25–0.5 mg BID → min effective	Usual 0.5–2 mg (max 4)	PO	Short-term only	Dependence, sedation; taper to stop; long half-life (less interddose rebound than alprazolam)
Lorazepam	Bridge for severe anxiety	0.5–1 mg BID–TID → min effective	Usual 1–3 mg (max 6)	PO	Short-term only	As above; respiratory/CNS depression with alcohol/ opioids; no active metabolites- safer in hepatic impariment (vs diazepam/ alprazolam)
Alprazolam (benzodiaze pine)	Bridge for severe acute anxiety/ panic	0.25–0.5 mg up to TID → ↑ by 0.25–0.5 mg/day q3–4 days	Keep **≤4 mg/day** in practice (use lowest effective)	PO	**Short-term only**; taper to stop	Dependence/withdrawal (seizure risk if abrupt stop), sedation; **CYP3A4** interactions (e.g., azoles, macrolides, grapefruit); avoid alcohol/opioids; lower doses in older/hepatic impairment; high abuse vs lorazepam, clonazepam, short half-life= higher rebound anxiety.

PO = by mouth; OD = once daily; BID/TID = twice/three times daily; q = every; PRN = as needed.

General cautions across agents: suicidality monitoring in youth; serotonin syndrome with serotonergic combinations; pregnancy/lactation risk–benefit; taper SSRIs/SNRIs to avoid discontinuation (fluoxetine less so); avoid long-term benzodiazepines.

Assessment of response, review; follow-up and treatment adjustment

- Monitor: GAD-7/HADS-A/PDSS (baseline → every visit), function (work/school/social), side effects, adherence.

- Frequency: 2–4 weeks during initiation/changes; 4–8 weeks in stabilization; 3–6 months in maintenance or sooner if relapse.
- Before changing therapy: confirm diagnosis, check comorbidities (depression/ substance use), adherence, triggers, and tolerability.

Decision	When (criteria)	What to do
Step-up (intensify)	After 6–8 weeks of optimal therapy with inadequate response, or functional decline, recurrence, worsening avoidance, or emergent depression	Increase dose (within limits); switch to another first-line agent; augment with buspirone, mirtazapine, or propranolol for performance anxiety; intensify psychotherapy. Consider short-term bridge with alprazolam only for severe acute distress, then taper.
Step-down (de-escalate)	Stable remission 6–12 months	Taper medicines slowly over weeks–months; continue psychotherapy and lifestyle measures; monitor for relapse/ withdrawal and reinstate/adjust if symptoms return.

Referral (tiered approach)

- Primary → Secondary/Tertiary: severe/persistent symptoms, suicidal risk, complex comorbidity (major depression, bipolar disorder, substance use), marked functional impairment, diagnostic uncertainty.
- Secondary → Tertiary: treatment-resistant cases, need for advanced psychotherapies, inpatient care, or complex medication monitoring.
- Pathways: use telepsychiatry/outreach where specialists are scarce; send a concise summary (timeline, prior treatments/doses/durations, responses/adverse effects, comorbidities, current meds/allergies, safety plan).

Complications

- Depression, substance misuse, suicide risk, and social/occupational decline (productivity loss, relationship strain). Benzodiazepine dependence with prolonged use.

Patient education & instructions to patient/caregiver

- Take medicines exactly as prescribed; do not stop abruptly.
- Keep follow-ups; track symptoms with a simple scale (e.g., GAD-7).
- Daily stress-reduction practice; exercise and sleep routine; limit caffeine/alcohol/ nicotine.
- Caregivers watch for early relapse (rising worry, panic, avoidance); seek help early.
- Red flags (urgent care): suicidal thoughts, severe worsening, substance binges/ withdrawal.
- Expect long-term management even when better; focus on relapse prevention.

INTRODUCTION

Anxiety disorders are a group of mental health conditions marked by excessive fear, worry, and related behavioral disturbances that impair daily functioning and quality of life. While anxiety can be a normal adaptive response to stress, it becomes a disorder when it is disproportionate, persistent, and significantly interferes with well-being, requiring clinical intervention. They are common worldwide: lifetime prevalence 16–29%, annual 7–10% in adults. In Southeast Asia, about 13.2% of people live with a mental health condition (~260 million); anxiety estimates of 3–5% are likely underreported due to stigma and limited access. Women are affected more than men; onset is usually in adolescence or early adulthood.Prevalence is up to 10% in children (school refusal, somatic complaints) and up to 11% in older adults. Anxiety raises risks of suicide, cardiovascular disease, and disability, but most cases respond to timely diagnosis plus psychological and, when indicated, pharmacological treatment.

Although anxiety disorders are not directly fatal, they increase the risk of suicide, cardiovascular disease, and functional disability. Most cases can be effectively controlled with timely diagnosis and a combination of psychological and pharmacological interventions. Early recognition limits chronicity, reduces comorbid depression or substance use, and preserves daily functioning. Avoid both under- and over-treatment: don’t dismiss symptoms or rely on reassurance alone, and avoid prolonged benzodiazepines, polypharmacy, or unnecessary tests. Use standardized assessment, choose treatments rationally, and refer when needed.

SCOPE OF THE GUIDELINES

These guidelines address diagnosis and management of common anxiety disorders—generalized anxiety disorder (GAD), panic disorder, social anxiety disorder, specific phobias, agoraphobia, and separation anxiety. Obsessive–compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) are not covered.

- Primary care teams screen, make basic diagnoses, deliver brief interventions, start first-line medicines, and refer when needed.
- Secondary care (psychiatry, clinical psychology, internal medicine) confirms diagnoses, provides structured psychotherapy, optimizes medication, and manages comorbidities.
- Tertiary centers handle complex or refractory cases, offer advanced therapies, train providers, and support research. Emergency clinicians, community health workers, and policymakers support implementation and oversight.

In resource limited settings, where resources and specialist availability are limited, bridging strategies through telepsychiatry for remote consultations, the use of standardized screening tools like GAD-7 and PHQ-9, training primary care physicians in brief cognitive-behavioral therapy (CBT) techniques or psychotherapy, and implementing safe, standardized protocols for initiating and tapering medications.

DEFINITIONS OF ANXIETY DISORDERS (DSM-5)

Anxiety disorders are a group of psychiatric conditions characterized by excessive, persistent fear, worry, or apprehension, often accompanied by physical symptoms and behavioral changes that impair daily functioning. Fear is typically a response to a real or perceived imminent threat, while anxiety is a more diffuse anticipation of a future threat. In anxiety disorders, these responses are disproportionate to the actual situation, occur in inappropriate contexts, or persist beyond the period of potential threat. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), recognizes several distinct anxiety disorders, each with specific diagnostic criteria:

1. **Generalized Anxiety Disorder (GAD):**A chronic condition marked by excessive, uncontrollable worry about various aspects of life (e.g., health, work, finances), occurring on most days for at least six months. The worry (apprehensive expectation) is accompanied by symptoms such as restlessness, fatigue, muscle tension, irritability, poor concentration, and sleep disturbances. The intensity, duration or frequency of these symptoms is out of proportion to the actual likelihood or impact of the anticipated event, Anxiety is not limited to a specific trigger and causes significant impairment.

2. **Panic Disorder:** Characterized by recurrent, unexpected panic attacks—abrupt surges of intense fear or discomfort that peak within minutes—accompanied by physical symptoms such as palpitations, sweating, trembling, shortness of breath, chest pain, nausea, dizziness, and fear of losing control or dying. Individuals often develop persistent concern about future attacks or maladaptive behavioral changes (e.g., avoiding situations where attacks occurred).

3. **Social Anxiety Disorder (Social Phobia):** An intense, persistent fear of social or performance situations where one may be exposed to possible scrutiny by others, leading to avoidance or severe distress. Individuals fear negative evaluation, embarrassment, or humiliation. Common triggers include public speaking, meeting strangers, or eating in public.

4. **Specific Phobias:** Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, injections), which is avoided or endured with intense distress. The fear is out of proportion to the actual danger and persists for six months or more.

5. **Agoraphobia:** Fear or avoidance of situations where escape may be difficult or help unavailable if panic-like or embarrassing symptoms occur. Commonly includes avoidance of open spaces, crowded places, enclosed areas, public transport, or being outside alone. Often develops in the context of panic disorder but can occur independently.
6. **Separation Anxiety Disorder (in adults):** Persistent, excessive fear or anxiety about separation from home or attachment figures, extending beyond developmentally appropriate periods. In adults, it may manifest as extreme distress when away from loved ones, persistent worry about harm to them, and reluctance to travel or sleep away from home.

CAUSES, RISK FACTORS, AND TRIGGERS

Anxiety disorders result from the interplay of biological, psychological, and social influences, with various situational triggers capable of precipitating or worsening symptoms.

Dimension	Key mechanisms / factors	Examples / notes	Clinical relevance
Biological	Genetic predisposition; neurotransmitter imbalance (serotonin, gamma-aminobutyric acid [GABA], noradrenaline); hyperactive amygdala	Family history of anxiety; dysregulated mood/arousal circuits	Higher baseline vulnerability; may guide pharmacotherapy choices
Psychological	Maladaptive coping, perfectionism, unresolved early-life trauma	Catastrophizing, intolerance of uncertainty	Lower resilience; targets for psychotherapy (e.g., cognitive behavioral therapy)
Social	Chronic stressors, isolation, financial hardship, unstable housing	Job insecurity, caregiving strain, poor social support	Maintains/worsens anxiety; indicates need for social support and case management
Common triggers	Acute or chronic stressors precipitating onset/relapse	Health scares, bereavement, relationship breakup, occupational stress, chronic illness	Trigger management and relapse prevention planning (psychoeducation, early intervention)

EVALUATION FOR DIAGNOSIS

The diagnostic evaluation of anxiety disorders involves a structured clinical assessment to confirm the presence, type, and severity of symptoms, while ruling out other medical or psychiatric conditions.

Domain	What to assess	Tools / measures	How to use the result
Structured clinical history	Onset, duration, pattern; triggers; avoidance; impact on work/home/ sleep; safety (suicidality)	Semi-structured interview	Confirms presence, type, and functional impairment of anxiety symptoms
Psychiatric/ medical/ substance history	Past psychiatric illness; family history of anxiety/mood disorders; alcohol/drugs; medical illnesses; meds (e.g., stimulants, thyroid meds)	Chart review; collateral where relevant	Identifies comorbidity and contributors; guides choice of therapy/ referral
Mental status examination	Mood, affect, thought content/ process, insight, judgment; hyperarousal signs (restlessness, fidgeting, pressured speech)	Bedside MSE	Supports diagnosis, gauges severity, rules in/out psychosis or severe depression
Screening & severity scales	Baseline severity and monitoring	Generalized Anxiety Disorder-7 (GAD-7): 7 items, 0–3 each; total 0–21 → 5/10/15 = mild/moderate/ severe. Hospital Anxiety and Depression Scale (HADS-A): 7 anxiety items, 0–3 each; 0–7 normal, 8–10 borderline, ≥11 abnormal. Panic Disorder Severity Scale (PDSS): 7 items, 0–4 each; total 0–28; higher = more severe (panic-specific). Hamilton Anxiety Rating Scale (HAM-A): 14 items, 0–4 each; total 0–56 (commonly: <17 mild, 18–24 moderate, 25–30 severe).	Quantifies severity, tracks response; helps select and adjust treatment
Physical examination	Vitals; thyroid/eye signs; cardiopulmonary exam (arrhythmia, wheeze); neuro screen	Focused exam	Excludes mimics (e.g., hyperthyroidism, arrhythmia, asthma, neurologic disease)
Laboratory & ancillary tests	Thyroid function, fasting glucose, complete blood count, electrolytes; electrocardiogram (ECG) if palpitations; vitamin B12/folate when deficiency risk (malabsorption, poor diet, long-term metformin, proton-pump inhibitors/H2 blockers)	Targeted labs; ECG	Rules out metabolic/ endocrine/cardiac causes (anemia, thyroid disease, electrolyte issues); assesses comorbid megaloblastic anemia (cognitive/ neuropathy) when suspected

Clinical Features

Anxiety disorders present with a mix of psychological, physical, and behavioral symptoms, but the pattern varies by type. Recognition of these distinct profiles is essential for accurate diagnosis and treatment planning.

Disorder	Core features	Common symptoms/signs	Avoidance/impact	Remarks
Generalized Anxiety Disorder (GAD)	Excessive, uncontrollable worry about multiple domains for ≥6 months	≥3 of: restlessness, muscle tension, fatigue, irritability, poor concentration, sleep disturbance; physical complaints (headache, GI upset, palpitations)	Functional impairment across work/home/social roles	Similar features in older adults; sub-syndromal presentations common
Panic Disorder	Recurrent, unexpected panic attacks (surges of intense fear peaking within minutes)	≥4 of: palpitations, chest pain, dyspnea/choking, heat sensations, nausea/ abdominal distress, dizziness, sweating, trembling, numbness, derealization/ depersonalization, fear of losing control/dying	Persistent worry about future attacks and maladaptive avoidance	Attacks are abrupt and time-limited; consider medical mimics if atypical
Social Anxiety Disorder (Social Phobia)	Marked fear of social/performance situations with possible scrutiny	Blushing, sweating, trembling, tachycardia during exposure	Avoids public speaking, gatherings, meeting new people; impaired performance/ participation	Fear centers on embarrassment, humiliation, or rejection
Specific Phobias	Intense, irrational fear of a specific object/situation	Immediate anxiety or panic on exposure	Avoids triggers (e.g., heights, animals, injections, flying); interferes with functioning	Fear disproportionate to actual danger
Agoraphobia	Fear/avoidance of ≥2: public transport, crowded places, open spaces, enclosed spaces, being outside alone	Anxiety about difficult escape or lack of help if panic-like symptoms occur	Avoids listed settings; significant role limitation	Often co-occurs with Panic Disorder but can occur independently

Across all types, hyperarousal symptoms—such as increased heart rate, rapid breathing, muscle tension, sweating, and gastrointestinal distress—are frequent. Functional impairment in work, education, and social life is a unifying feature of clinically significant anxiety disorders.

CONFIRMATION OF DIAGNOSIS

Requirements: (1) Symptoms meet DSM-5/ICD-11 criteria, (2) functional impairment present, (3) medical/substance causes excluded.

Refer to a psychiatrist/clinical psychologist when symptoms are atypical, severe, or treatment-resistant.

Why it matters: enables correct treatment and helps avoid benzodiazepine overuse and unnecessary tests.

CLASSIFICATION & SEVERITY ASSESSMENT

Classification: by disorder type per DSM-5/ICD-11 (based on symptom pattern and trigger context).

Severity drivers:

- Symptom intensity/frequency (mild–moderate–severe)
- Functional impairment (work/school/relationships/daily living)
- Physiological/autonomic signs (tachycardia, hyperventilation, sweating, GI distress)
- Risk factors (depression, substance misuse, suicidal ideation, medical comorbidity)

Rating tools:

- GAD-7 (Generalized Anxiety Disorder-7): 5/10/15 = mild/moderate/severe
- HAM-A (Hamilton Anxiety Rating Scale): <17 mild; 18–24 moderate; ≥25 moderate to severe
- Disorder-specific: PDSS (Panic Disorder Severity Scale), LSAS (Liebowitz Social Anxiety Scale)
- Reassess regularly—severity fluctuates and treatment should adjust accordingly.

In Low-resource settings

- Take a chronological, detailed history (patient ± informant).
- Do a targeted physical/neurological exam to exclude organic triggers.
- Use brief validated screens (e.g., GAD-7) to quantify symptoms.
- Document duration, onset pattern, triggers, and functional impact.

DIFFERENTIAL DIAGNOSIS

Anxiety disorders must be distinguished from other psychiatric, medical, and substance-related conditions to ensure correct diagnosis and treatment.

Domain	What to consider	How it overlaps with anxiety	How to differentiate / what to do
Psychiatric	Depression; obsessive–compulsive disorder (OCD); post-traumatic stress disorder (PTSD); adjustment disorder; somatic symptom disorders	Worry, tension, sleep problems, autonomic symptoms	Full psychiatric history; screen for low mood/anhedonia, trauma re-experiencing, compulsions; use disorder-specific scales; treat primary condition if present
Medical	Hyperthyroidism, arrhythmias, asthma, neurological conditions	Palpitations, dyspnea, tremor, dizziness	Targeted exam; thyroid tests, ECG, spirometry, basic neuro screen; manage identified medical cause
Substance-related	Caffeine/stimulant intoxication; alcohol/benzodiazepine withdrawal; medication side effects (e.g., bronchodilators, steroids, thyroid meds)	Agitation, tremor, tachycardia, insomnia	Time-link symptoms to use/withdrawal; review meds; toxicology if needed; taper/stop culprit, treat withdrawal safely
Normal stress response	Short-term, proportionate anxiety to clear stressor (exam, interview)	Transient worry and arousal	Reassure, brief coping advice; diagnose a disorder only if persistent, disproportionate, or impairing
Evaluation principles	Careful history, exam, targeted tests	Many mimics/comorbidities	Document onset, duration, triggers, functional impact; rule out organic causes; identify comorbidities that shape treatment
Screening + judgment	GAD-7/HADS/PDSS with clinician assessment	Scores alone can mislead	Use scales to quantify/severity-track; confirm with clinical judgment; co-existing conditions guide prognosis and plan

MANAGEMENT GOALS

- Reduce symptom severity, restore functioning, and improve quality of life.
- Relieve excessive fear/worry and physical symptoms; prevent relapse and chronicity.
- Address comorbidities (depression, substance use), build coping skills, and enhance stress resilience.
- Individualize care early to avoid long-term disability and sustain remission.

MANAGEMENT PRINCIPLES

- **Psychoeducation first:** explain illness, triggers, and treatment roles to patients/ caregivers.
- **First-line treatments:** structured psychotherapy especially CBT psychotherapy and, when indicated, medication with selective serotonin reuptake inhibitors (SSRIs) or serotonin–norepinephrine reuptake inhibitors (SNRIs).
- **Benzodiazepines:** short-term, cautious use only due to dependence risk.
- **Monitor and adjust:** track symptoms, side effects, and functioning; step up or down treatment as needed.
- **If partial response:** consider augmentation (e.g., small-dose antipsychotic), adding another anxiolytic, and/or additional non-pharmacologic therapy.
- **Lifestyle & skills:** exercise, sleep hygiene, relaxation/mindfulness; manage medical/ psychiatric comorbidities.
- **Long-term plan:** continuity of care, relapse-prevention strategies, and gradual medication taper when appropriate.

APPROACH TO MANAGEMENT OF DIFFERENT TYPES OF ANXIETY DISORDERS

The approach to managing different types of anxiety disorders combines evidence-based psychotherapy, pharmacotherapy, and supportive measures, tailored to the specific diagnosis.

Disorder	Core psychotherapy	First-line meds	Key notes / duration / cautions
Generalized anxiety disorder (GAD)	CBT/ psychotherapy – worry management, problem-solving, sleep hygiene	SSRIs or SNRIs	Continue meds 6–12 months after remission, then taper slowly
Panic disorder	CBT/ psychotherapy with interoceptive and situational exposure; psychoeducation on benign nature of attacks	SSRIs/SNRIs; benzodiazepines short-term only (while initiating antidepressant)	Exclude medical mimics first; avoid long-term benzodiazepines
Social anxiety disorder	CBT/ psychotherapy with social-skills training and graded exposure	SSRIs when impairment is moderate–severe or CBT access limited	Performance-only: propranolol PRN before events (avoid in asthma/bradycardia)
Specific phobias	Exposure-based therapy (in-vivo/ virtual)	Medication usually not indicated	Reserve meds for comorbidity; focus on systematic exposure
Agoraphobia	CBT/ psychotherapy with gradual supported exposure	SSRIs/SNRIs for marked impairment or comorbidity	Combine meds + CBT when possible
Separation anxiety disorder (adults)	CBT/ psychotherapy targeting attachment fears and safety-seeking; psychoeducation	SSRIs for persistent/ severe cases	Plan relapse-prevention and taper carefully
All disorders (supportive measures)	Psychoeducation; stress management, relaxation/ mindfulness; sleep and exercise routines	—	Address comorbid depression/ substance use/medical issues; schedule regular follow-up; use scales (e.g., GAD-7, PDSS, LSAS) to track progress; avoid long-term benzodiazepines

Across all types, treatment should include lifestyle modifications, stress management, addressing comorbidities, and ensuring regular follow-up to prevent relapse.

PHARMACOLOGICAL THERAPY

Pharmacological treatment should be individualized based on the type of anxiety disorder, severity, comorbidities, patient preference, and prior treatment history. First-line options are selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), with other agents used as adjuncts or for specific indications.

Selective Serotonin Reuptake Inhibitors (SSRIs)

1. Fluoxetine: Fluoxetine: Start at 10 mg PO increase to 20 mg once daily (in morning) after 1–2 weeks; further ↑ by 10–20 mg q2–4 weeks; max dose 60–80 mg/day (use lowest effective; higher doses (above 60 mg/day) are reserved for treatment-resistant cases and require close monitoring.

   Or

   Escitalopram: Start 5–10 mg orally once daily; titrate to 10–20 mg/day. Or Sertraline: Start 25–50 mg orally once daily; titrate gradually to 100–200 mg/day.

   Duration: Therapeutic effects may take 4–8 weeks to fully manifest. Continue at effective dose for at least 6–12 months after remission; longer for recurrent or severe cases.

Cautions: Use fluoxetine cautiously: start low and go slow, as early activation can worsen anxiety; watch for serotonin syndrome, especially with other serotonergic drugs, and don't stop abruptly—taper if on higher doses. Monitor for suicidality in children, adolescents, and young adults; fluoxetine is a strong CYP2D6 inhibitor and raises levels of many medicines (e.g., tricyclics, antipsychotics, some beta-blockers; may reduce tamoxifen efficacy). Dose in the morning to limit insomnia; bleeding risk rises with NSAIDs, anticoagulants, or antiplatelets—consider gastroprotection. Check sodium in older adults or those on diuretics (hyponatremia/SIADH); screen for bipolar disorder (mania risk), use caution in epilepsy (seizure threshold), weigh risks in pregnancy/lactation due to possible neonatal adaptation, watch additive QT-prolongation, and reduce dose or extend intervals in hepatic impairment.

Or

First-Line Alternative- Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) in GAD, Panic Disorder, Social Anxiety Disorder and in patients with comorbid neuropathic pain or fatigue

Venlafaxine XR: Start 37.5–75 mg orally once daily; titrate to 75–225 mg/day. Continue at effective dose for at least 6–12 months after remission; longer for recurrent or severe cases. **Cautions**: Monitor blood pressure (dose-related increases possible). Gradual tapering required to avoid discontinuation symptoms.

2. **Benzodiazepines :** – Short-Term Use Only in severe acute anxiety or panic attacks or as a bridge therapy while waiting for SSRIs/SNRIs to take effect

   Clonazepam: Start 0.25–0.5 mg orally twice daily; usual range 0.25–1 mg/day.

   Duration: Use for ≤2–4 weeks only; taper gradually to prevent dependence.

   Alprazolam: start 0.25–0.5 mg PO up to three times a day, for panic often 0.5 mg thrice a day; titrate by 0.25–0.5 mg/day every 3–4 days to the lowest effective dose; in general practice keep total ≤4 mg/day, review within 1–2 weeks, and taper (e.g., 10–25% every 3–7 days) to stop.

   Cautions: High risk of tolerance, dependence, and withdrawal. Avoid in patients with history of substance misuse. Sedation, cognitive impairment, and psychomotor slowing may occur.

   Note: Clonazepam's smoother, longer action makes it safer and easier to manage than alprazolam for short-term control—though both carry dependence and sedation risks and should be used briefly while SSRIs/SNRIs and therapy do the heavy lifting.

2. **Add an Adjunctive Medication** particularly in patients who do not tolerate SSRIs/SNRIs or with have substance use risk:

   Buspirone: Start 5–7.5 mg orally twice daily; titrate to 20–30 mg/day in divided doses.

   Duration: Onset may take 2–4 weeks; continue for several months as indicated.

Cautions: Not effective for acute anxiety or panic attacks. Avoid MAOIs (risk of hypertensive crisis).

Or

Gabapentin: Start: 100–300 mg at night, then increase by 100–300 mg/day every 1–3 days. Effective range: 900–1,800 mg/day in 2–3 divided doses (twice or thrice a day). Use as **adjunct** when first-line therapy (CBT, SSRI/SNRI) is inadequate or when comorbid neuropathic pain/insomnia is present.

Caution: Adjust dose in renal impairment, sedation, dizziness/ataxia, edema/ weight gain; respiratory depression risk with opioids or other CNS depressants; misuse potential; driving impairment. Few drug interactions (renally cleared) but antacids can reduce absorption. Taper over ≥1 week to stop.

Note: All medication adjustments should be made gradually to minimize side effects, with close monitoring for serotonin syndrome when combining serotonergic agents.

Propranolol: Best for performance-only social anxiety and somatic symptoms (palpitations, tremor) rather than generalized worry; also useful when akathisia or hyperthyroid-related tremor co-exist.

Start with as-needed (PRN) dose: 10–40 mg orally, 30–60 minutes before the event (test speech first at home). For short courses of daytime physical symptoms: 10–20 mg, 1–3 times daily; use the lowest effective dose.

Cautions/contraindications: asthma or chronic obstructive pulmonary disease (bronchospasm with non-selective beta-blockers), bradycardia, hypotension, second/third-degree heart block, decompensated heart failure, diabetes (masks hypoglycemia), peripheral vascular disease, depression, pregnancy (use only if benefits outweigh risks). Watch for fatigue, dizziness, cold extremities, vivid dreams. Drug interactions: levels may rise with strong CYP2D6 inhibitors (e.g., fluoxetine/paroxetine; both are selective serotonin reuptake inhibitors [SSRIs]); additive effects with other antihypertensives. Not a first-line treatment, use to augment cognitive behavioral therapy (CBT) and/or serotonin–norepinephrine reuptake inhibitors (SNRIs)/SSRIs.

Treatment Options for Anxiety Disorders in Patients with Comorbidities, Special Conditions and Sleep Problems

Management of anxiety disorders in patients with co-morbid conditions or sleep disturbances requires an integrated, individualized approach to ensure safety, avoid drug interactions, and address overlapping symptoms.

Co-morbid Physical Illness

- **Cardiovascular disease:** Use SSRIs such as sertraline or escitalopram as first-line agents due to their favorable cardiac safety profile; avoid tricyclic antidepressants and high-dose venlafaxine because of potential arrhythmogenic effects.

- **Chronic respiratory disease:** Avoid benzodiazepines in patients with COPD or sleep apnea due to risk of respiratory depression; prefer buspirone or SSRIs.
- **Chronic pain syndromes:** SNRIs like duloxetine or venlafaxine can target both anxiety and pain symptoms.
- **Endocrine disorders (e.g., thyroid dysfunction, diabetes):** Stabilize the underlying endocrine condition first, as an untreated imbalance can worsen anxiety. Use SSRIs/SNRIs with monitoring for glycemic and metabolic effects

Co-morbid Psychiatric Conditions

- **Depression:** Choose agents effective for both anxiety and depression, such as escitalopram, sertraline, or venlafaxine.
- **Substance use disorders:** Avoid benzodiazepines; focus on SSRIs/SNRIs and CBT/psychotherapy. Consider referral to addiction services.

Special Condition

- **Pregnancy:** Preferably avoid psychotropics during the first trimester of Pregnancy and advise non-pharmacological strategies first including enrolling patients in antenatal programs. Especially, avoid paroxetine and benzodiazepines use among pregnant women or women planning to become pregnant.
- **Elderly:** SSRI use appears to be safe; start low, go slow. Avoid unnecessary benzodiazepine use to avoid falls, confusion & agitation.
- **Children and adolescents**: Choice of treatment should be Fluoxetine; careful monitoring due to concerns about increased risk of suicidal ideation and behavior.

Sleep Problems

- **Insomnia associated with anxiety:**
  - Non-pharmacological: Cognitive Behavioral Therapy for Insomnia (CBT-I)/psychotherapy, relaxation training, sleep hygiene education.
  - Pharmacological (short-term, if needed): Non-benzodiazepine hypnotics like zolpidem (5–10 mg at bedtime) or sedating antidepressants like mirtazapine (7.5–15 mg at bedtime) in patients without obesity or metabolic syndrome.
  - Avoid long-term sedative-hypnotic use; reassess regularly.
- **Hypersomnia:** Evaluate depression, medication side effects, or sleep disorders (e.g., sleep apnea); manage underlying cause.

Integrated Care Principles

- Always treat the most severe or destabilizing condition first.

- Use the lowest effective dose of psychotropics and titrate slowly in medically complex patients.
- Coordinate care between primary care, psychiatry, and relevant specialists to ensure safety and avoid polypharmacy.
- Monitor regularly for changes in symptoms, side effects, and impact on co-morbid conditions.

NON-PHARMACOLOGICAL INTERVENTIONS

Non-pharmacological approaches are essential in both acute and long-term management of anxiety disorders. They can be used alone in mild cases or combined with medication for moderate to severe cases. They focus on addressing underlying causes, modifying maladaptive thought patterns, improving coping mechanisms, and reducing relapse risk.

1. Psychotherapy (First-Line for Many Cases)

- Cognitive Behavioral Therapy (CBT): Evidence-based gold standard. Helps identify and modify distorted thinking, challenge avoidance behaviors, and develop adaptive coping strategies. Generally, 12–20 sessions. If CBT is not available, practical psychotherapy options can be exercised (see below).
- Exposure Therapy: Gradual, controlled exposure to feared situations or stimuli, useful for phobias, panic disorder, and social anxiety disorder.
- Mindfulness-Based Therapies: Incorporate meditation, body awareness, and acceptance-based techniques to reduce rumination and hypervigilance.

2. Psychoeducation

- Educate patients and families about the nature of anxiety disorders, precipitating factors, course of illness, and treatment options.
- Emphasize that anxiety is treatable and not a sign of weakness.
- Provide clear strategies for early symptom recognition and relapse prevention.

3. Lifestyle Modifications

- Sleep hygiene: Regular sleep–wake cycles, avoiding stimulants before bedtime.
- Regular physical activity: Moderate aerobic exercise 30–40 minutes, 3–5 times/week, shown to reduce anxiety symptoms.
- Balanced nutrition: Avoid excess caffeine, refined sugars, and alcohol.

- Stress reduction: Incorporate relaxation techniques such as deep breathing, progressive muscle relaxation, and guided imagery.

4. Social Support and Community Interventions

- Strengthen family and peer support systems to reduce isolation.
- Encourage participation in group therapy or support groups for shared experiences and coping strategies.
- Leverage community health workers to maintain follow-up and reinforce treatment adherence, especially in resource-limited settings.

5. Workplace and School Interventions

- Flexible schedules or workload adjustments during acute phases.
- Anti-stigma campaigns in schools and workplaces.
- Counselling services within educational institutions for children and adolescents.

6. Telehealth and Digital Tools

- Use of telepsychiatry for remote areas with limited specialist availability.
- Mobile apps offering guided CBT, mindfulness exercises, and mood tracking.

Practical psychotherapy options when cognitive behavioral therapy (CBT) isn't available:

- **Psychoeducation + self-management**: brief sessions on the anxiety cycle, avoidance, sleep, caffeine/alcohol limits; give a simple action plan and relapse-warning signs.
- **Exposure-based therapy**: build a graded fear hierarchy and practice **in-vivo** (real-life) or **interoceptive** (body-sensation) exposure; cornerstone for panic, phobias, agoraphobia.
- **Applied relaxation & breathing skills**: diaphragmatic breathing, progressive muscle relaxation, cue-controlled relaxation; daily practice.
- **Mindfulness-based programs**: mindfulness-based stress reduction (MBSR) or mindfulness-based cognitive therapy (MBCT) to reduce worry and rumination.
- **Acceptance and Commitment Therapy (ACT)**: values clarification, acceptance of internal experiences, and committed action to reduce avoidance.

- **Problem-solving therapy (PST)**: structured steps to tackle practical stressors fueling anxiety.
- **Short-term psychodynamic psychotherapy**: for patients with interpersonal/ attachment themes or when preferred.
- **Group formats / guided self-help**: clinician-led groups or credible workbooks/ apps when specialists are scarce.

How to run it: 6–10 brief weekly sessions, set homework, use simple scales (e.g., GAD-7) to track progress, and combine with first-line medication when impairment is moderate–severe. Avoid long-term benzodiazepines.

ANXIETY DISORDERS IN CHILDREN

- Roughly 5–8% of children and adolescents have an anxiety disorder at any given time.
- By late adolescence, 15–20% will have met criteria at least once.
- Rates are higher in girls (especially after puberty), and many cases go unrecognized because symptoms present as stomachaches, headaches, irritability, or school refusal.

Management of pediatric anxiety

- **Presentation & history**: Children show more somatic complaints (headache, stomachaches), school refusal, irritability, and separation fears; adults report cognitive worry. Diagnosis in kids relies on multi-informant input (child, caregiver, school) and developmental norms.
- **Comorbidity pattern**: In children, screen for attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), learning issues, and bullying; adults more often have depression/substance use.
- **Assessment tools**: Prefer child tools—Screen for Child Anxiety Related Emotional Disorders (SCARED), Revised Child Anxiety and Depression Scale (RCADS)—plus teacher reports. Adult tools (e.g., Generalized Anxiety Disorder-7 [GAD-7]) are secondary in youth.
- **Differential diagnoses**: Rule out neurodevelopmental disorders and selective mutism in children; medical mimics in both (thyroid, asthma, arrhythmia).

- **First-line treatment: Psychotherapy firs**t in children—family-based cognitive behavioral therapy (CBT) with graded exposure, parent training to reduce accommodation, and a school plan (graded attendance, classroom supports). Adults: individual CBT is usually sufficient.
- **Medication use**: In children, use selective serotonin reuptake inhibitors (SSRIs) only for moderate–severe cases or CBT non-response; start low, go slow, weight/age guided, and monitor suicidality closely. Benzodiazepines are generally avoided in children (disinhibition, dependence); adults may receive brief bridges.
- **Settings & supports**: Pediatric care integrates caregivers and school; adults focus on workplace and individual coping. Safety planning in adolescents is routine.
- **Follow-up & taper**: Longer skill consolidation in kids; maintain gains through parent-led practice and school exposure. Taper SSRIs slowly after 6–12 months of remission in both, with closer monitoring in youth.

ASSESSMENT OF RESPONSE

Evaluating treatment response is essential to determine whether the chosen therapy is achieving the intended outcomes and to guide necessary adjustments. This should be done systematically, beginning at baseline and repeated at defined follow-up intervals.

Key components include:

Component	What to assess	How to measure/track
Symptom rating scales	Change in anxiety severity	Validated tools at baseline and follow-up: Generalized Anxiety Disorder-7 (GAD-7), Hamilton Anxiety Rating Scale (HAM-A)
Functional improvement	Daily living, work/academics, social participation	Brief functional check (work/school attendance, role performance, social engagement)
Side-effect profile	Sedation, GI upset, weight change, withdrawal symptoms	Structured adverse-effect review; vitals/weight where relevant; balance benefits vs risks

Regular, structured assessments enable early detection of non-response, guide step-up or step-down therapy, and improve long-term outcomes.

Phase	Assessment frequency	Purpose
Initial	Every 2–4 weeks after starting or adjusting treatment	Monitor early response, adherence, tolerability; decide on step-up/step-down
Stabilization	Every 4–8 weeks until remission/ optimal control	Optimize regimen; track symptom and function trends
Maintenance	Every 3–6 months (earlier if symptoms recur)	Sustain gains, prevent relapse, detect non-response early

FOLLOW-UP AND ADJUSTMENT

Ongoing follow-up is critical to ensure that anxiety symptoms remain controlled, treatment is well-tolerated, and functional recovery is maintained. The process involves structured monitoring, timely intervention when needed, and gradual adjustment of therapy based on patient progress.

Phase / Decision	When (criteria)	What to do	Remarks
Ongoing follow-up	Continuous, from initiation through maintenance	Structured monitoring of symptoms, function, side effects, and adherence; adjust therapy based on progress	Goal: sustained control, good tolerability, preserved functioning
Step-UP treatment	Inadequate improvement after 6–8 weeks of optimal therapy or functional decline, recurrent panic attacks, worsening avoidance, emergent depression	Increase dose (within recommended limits); switch to an alternative first-line agent; add adjunct (e.g., buspirone, pregabalin); intensify psychotherapy	Reassess diagnosis, comorbidities, adherence, and triggers before changes
Step-DOWN treatment	Stable remission for 6–12 months	Gradual medication taper over weeks–months; continue psychotherapy and lifestyle measures during/after taper	Aim to minimize long-term exposure and relapse risk; monitor for withdrawal/ relapse
Shared decision-making	At each review point	Engage patient in choices about dose changes, switches, augmentation, and tapering	Improves adherence and outcomes; document plan and safety net instructions

A collaborative approach—engaging the patient in shared decision-making—improves adherence and outcomes, while timely step-up or step-down adjustments ensure individualized, effective long-term care.

PROGNOSIS

The prognosis of anxiety disorders is generally favorable with timely recognition and appropriate treatment, as most patients achieve significant symptom reduction and functional improvement.

- Early intervention with evidence-based pharmacological and non-pharmacological therapies greatly reduces the risk of chronicity, comorbid depression, substance misuse, and disability. However, untreated or partially treated cases may persist for years, leading to recurrent episodes and impaired quality of life.
- Prognosis varies by subtype—specific phobias often respond rapidly to targeted exposure therapy, while generalized anxiety disorder and panic disorder may require longer-term management.

- Factors associated with a poorer prognosis include delayed diagnosis, severe baseline symptoms, coexisting psychiatric or medical conditions, and poor adherence to treatment or follow-up.
- In resource-limited settings, the absence of specialized care and limited access to psychotherapy can contribute to prolonged illness, underscoring the importance of primary care–based detection, structured protocols, and telepsychiatry support to optimize outcomes.
- Lifelong vigilance is needed for patients with recurrent or treatment-resistant anxiety to prevent relapse and maintain long-term remission.

REFERRAL LINKAGE

Referral in anxiety disorder management is essential when the patient's condition exceeds the diagnostic or therapeutic capacity of the current level of care.

Care level	Referral triggers / criteria	Refer to	Pathway & handoff notes
Primary care	Severe or persistent symptoms despite initial treatment; suicidal ideation/self-harm risk; complex comorbidities (major depression, bipolar disorder, substance use disorder); marked functional impairment limiting daily life	Secondary or tertiary mental health services	Use local pathways; where workforce is limited or geography is a barrier, use telepsychiatry or coordinated outreach clinics
Secondary care (psychiatrist/ clinical psychologist)	Treatment-resistant cases; need for advanced psychotherapies; need for inpatient care; complex medication management requiring specialized monitoring	Tertiary specialist center	Escalate via scheduled transfer or virtual case conference when feasible
All referrals	—	—	Send a clear summary: presenting problems and risk, timeline, prior treatments and doses/durations, response/adverse effects, medical/psychiatric comorbidities, current meds/allergies, supports/ safety plan. This preserves continuity and avoids delays or duplication.

- Referral pathways must account for limited psychiatric workforce and isolation, with telepsychiatry or coordinated outreach clinics serving as important bridging tools.

COMPLICATIONS

Anxiety disorders, when left untreated or inadequately managed, can lead to several significant complications.

Issue	What happens / why	Impact	Clinical response
Depression	Chronic distress and impairment fuel hopelessness → major depressive episodes	Lower QoL, poorer treatment response	Screen (e.g., PHQ-9), treat depression alongside anxiety; consider CBT and SSRI/SNRI adjustments
Substance misuse	Self-medication with alcohol/ sedatives/stimulants	Dependence, interactions, worse anxiety/ sleep	Screen (SBIRT), brief intervention, refer for addiction care; avoid benzodiazepines long term
Suicide risk	Higher with comorbid depression, severe/persistent anxiety	Self-harm, mortality	Routine risk assessment; safety plan, urgent referral/higher level care when indicated
Social & occupational decline	Avoidance and symptoms reduce productivity and relationships	Job loss, strain on families/ communities	Functional goals, graded exposure/ rehab, workplace/school accommodations, involve family supports

PREVENTION AND HEALTH PROMOTION

Prevention and health promotion in anxiety disorders focus on reducing risk factors, strengthening coping mechanisms, and fostering environments that support mental well-being, in line with the WHO Mental Health Gap Action Programme (mhGAP) Implementation Guide.

- **Primary prevention**: Public awareness to reduce stigma; promote exercise, sleep, balanced diet; avoid alcohol/drugs; early-life supports (positive parenting, school resilience and social–emotional learning, safe environments).
- **Secondary prevention**: Screen in primary care and high-risk groups; start psychological or medication treatment promptly to prevent chronicity.
- **Tertiary prevention**: Maintain remission with follow-up, psychoeducation, support networks, and self-management; ensure adherence and relapse prevention.

Cross-Cutting Strategies: Develop workplace wellness programs that include stress management workshops and mental health literacy. Strengthening community support groups and peer-led interventions. Integrate mental health services into primary care to ensure accessibility in both urban and rural areas and use telemedicine to reach remote communities.

PATIENT EDUCATION

- The objectives of patient education in anxiety disorders are to enhance the individual's understanding of their condition, including its causes, triggers, and treatment options, so they can actively participate in their care.
- Education should encourage adherence to prescribed therapies both pharmacological and non-pharmacological by explaining their benefits, expected timelines for improvement, and possible side effects.
- It should also focus on teaching practical coping skills, such as relaxation techniques, problem-solving strategies, and stress management practices, to empower patients in managing symptoms, reducing relapse risk, and improving overall quality of life.

Instructions to Patient/Caregiver

Do	Don't
Take medicines exactly as prescribed and keep a simple dose chart.	Stop or change medicines on your own.
Attend all follow-ups for monitoring and dose adjustments.	Miss appointments or skip recommended tests.
Exercise regularly within your health limits.	Push through strenuous workouts when unwell or overly anxious.
Eat a balanced diet and keep a regular sleep schedule.	Sacrifice sleep, skip meals, or rely on energy drinks.
Limit/avoid caffeine, alcohol, and nicotine; track triggers.	Use caffeine, alcohol, or nicotine to cope with anxiety.
Practice daily stress-reduction (breathing, mindfulness, guided relaxation).	Ignore stress management, hoping symptoms will pass on their own.
Caregivers: watch early signs (rising worry, panic, avoidance) and seek help early.	Dismiss early changes or delay seeking help.
Act immediately on red flags (severe distress, suicidal thoughts): seek urgent care.	Ignore or hide suicidal thoughts or severe worsening.
Expect long-term management; stick with the plan even when better.	Stop treatment as soon as symptoms improve.

REFERENCES

1. World Health Organization. Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: WHO; 2017.

2. Mental health conditions in the WHO South-East Asia Region. New Delhi: World Health Organization, Regional Office for South-East Asia; 2023. Licence: CC BY-NC-SA 3.0 IGO.

3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Arlington: APA; 2013.

4. National Institute for Health and Care Excellence. Generalized anxiety disorder and panic disorder in adults: management. NICE guideline CG113; 2020.

5. Bandelow B, Michaelis S, Wedekind D. Treatment of anxiety disorders. Dialogues Clin Neurosci. 2017;19(2):93–107.

6. Gautam S, Jain A, Gautam M, Vahia VN, Gautam A. Clinical Practice Guidelines for the Management of Generalized Anxiety Disorder (GAD) and panic disorder (PD). Indian J Psychiatry 2017; 59:67-73.

7. WHO *Mental Health Gap Action Programme (mhGAP) Implementation Guide.*