Introduction

With a lifetime prevalence of about 25%, anxiety disorders are among the most common psychiatric conditions in the general population, ranking just behind drug and alcohol abuse. The prevalence appears to be even higher among patients in primary care and specialty medical settings, resulting in excessive utilization of medical resources. Anxiety disorders exact a significant toll on the economy of the United States. One analysis put the total cost of anxiety disorders at $42.3 billion per year, the largest proportion of which is devoted to what is often excessive, repetitive, and unnecessary utilization of medical services. In addition, anxiety disorders are associated with marked distress and disability, increased marital, social, family, vocational, and financial instability, and, in some cases, increased and premature mortality. Anxiety disorders commonly occur comorbid with each other and other psychiatric difficulties, including mood disorders and alcohol and substance abuse, and with a variety of medical conditions. These comorbidities confer additional burden of illness on the affected individual and complicate the course of treatment.

Despite the availability of efficacious pharmacological and psychosocial therapies for anxiety disorders, many patients remain at least somewhat symptomatic. The importance of treating patients to remission has been increasingly emphasized over the last few years in assessing outcome for depressive disorders. The

New Advances in the Management of Anxiety Disorders

By Mark H. Pollack, MD

Abstract - Anxiety disorders are highly prevalent and associated with significant symptomatic distress, increased morbidity, and increased mortality. Although efficacious pharmacologic and psychosocial therapies for the anxiety disorders are available, many patients who improve with treatment remain at least somewhat symptomatic. This article reviews the epidemiology, phenomenology, and associated complications of panic disorder, social anxiety disorder, posttraumatic stress disorder, and generalized anxiety disorder. Recent guidelines developed for application in the assessment of outcome of the anxiety disorders are discussed, and illustrative data from a number of treatment trials integrating remission data in assessment of outcome are examined. Psychopharmacology Bulletin. 2002;36(suppl 3):79-94

Key Words: antidepressive agents, anxiety disorders, drug therapy, mood disorders, panic disorder, pharmacotherapy, phobic disorders, posttraumatic stress disorder, social phobia
goal of remission has recently started receiving more attention in the examination of treatments for anxiety disorders, with attempts made at establishing consensus treatment guidelines incorporating this concept.\(^5\)

In this article, we will discuss the presentation and epidemiology of some of the most common anxiety disorders—panic disorder (PD), social phobia, posttraumatic stress disorder (PTSD), and generalized anxiety disorder (GAD)—and review their pertinent psychiatric and medical definitions. We will present some of the recent guidelines developed for application in these disorders (Table) and examine illustrative data from a number of treatment trials that have integrated remission data in their assessment of outcome.

**GUIDELINES FOR REMISSION OF COMMON ANXIETY DISORDERS**

**PANIC DISORDER\(^*\)**

- Essentially free of panic attacks
- Mild or no agoraphobic avoidance
- Minimal or no anxiety; HAM-A score of ≤7–10
- No functional impairment; Sheehan Disability Scale score ≤1 on each item (mildly disabled)
- HAM-D score ≤7

**SOCIAL PHOBIA\(^*\)**

- Core symptoms of social anxiety have disappeared; LSAS score ≤30
- Minimal or no anxiety; HAM-A score ≤7–10
- No functional impairment; Sheehan Disability Scale score ≤1 on each item (mildly disabled)
- HAM-D score ≤7

**POSTTRAUMATIC STRESS DISORDER\(^†\)**

- Minimal or no PTSD symptoms; TOPS-8 score ≤5–6
- Minimal or no anxiety; HAM-A score ≤7–10
- No functional impairment; Sheehan Disability Scale score ≤1 on each item (mildly disabled)
- HAM-D score ≤7

**GENERALIZED ANXIETY DISORDER\(^*\)**

- Minimal or no anxiety; HAM-A score ≤7–10
- No functional impairment; Sheehan Disability Scale score ≤1 on each item (mildly disabled)
- HAM-D score ≤7

HAM-A=Hamilton Rating Scale for Anxiety; HAM-D=Hamilton Rating Scale for Depression; LSAS=Liebowitz Social Anxiety Scale; PTSD=posttraumatic stress disorder; TOPS-8=Treatment Outcome PTSD Scale.


NEW ADVANCES IN THE MANAGEMENT OF ANXIETY

Panic Disorder

Characterized by recurrent, unexpected panic attacks followed by at least 1 month of persistent anticipatory anxiety about future attacks, the implication of the attacks, or significant changes in behavior (eg, agoraphobic avoidance) related to the attacks, PD occurs in approximately 3% to 6% of the population. It occurs more frequently in women than in men, with an average age of onset in the 30s. However, more than half of adult patients with PD report having experienced significant anxiety difficulties during childhood. Although initial panic attacks appear to occur spontaneously, the majority of affected individuals identify a life stressor that appeared proximal to onset, heralding the disorder. The frequency and intensity of attacks vary widely, with some patients experiencing attacks on a daily basis and others at weekly or monthly intervals. Some patients reduce the frequency of their attacks by avoiding situations that trigger them, thus increasing associated disability. As a result, assessments focusing just on changes in frequency of panic can be inadequate measures with which to judge the true nature of a patient’s impairment and response to treatment. Comprehensive assessment of the severity of the PD syndrome, as reflected in an instrument such as the Panic Disorder Severity Scale, includes assessment not just of panic frequency but of anticipatory anxiety, agoraphobic avoidance, and functional impairment. Agoraphobia frequently accompanies PD in the clinical setting. It is diagnosed when patients experience fear or actual avoidance of situations in which they have previously experienced panic, from which escape may be difficult or embarrassing, or in which help is not readily available (eg, being alone, driving on a highway, being in crowds). Patients may additionally develop fears of exercise, caffeine, or activities or events that produce sensations of arousal reminiscent of anxiety or panic situations. Some patients push through the fear and enter feared situations despite their considerable anxiety while others avoid these situations, some becoming essentially homebound or requiring a companion to accompany them. Whereas the panic attacks are often dramatic and acutely distressing, it is often the anticipatory anxiety and agoraphobic avoidance that lead to the most impairment and functional disability.

Comorbid Conditions

Often, PD occurs with other psychiatric disorders, including other anxiety disorders such as social phobia, GAD, and PTSD. For instance, the presence of social phobia has been reported in approximately 40% of patients with PD, while GAD may occur in up to 30% of cases. A lifetime history of depression may occur in two thirds of patients with PD, with the depression either predating or emerging after the onset.
of panic. In some cases, the depression may reflect a reactive demoralization to the deleterious impact of PD on patients’ function and quality of life, while in other cases the comorbidity may indicate the emergence of two independent conditions. Recent attention has turned to the comorbidity of panic and bipolar disorder, with reports suggesting that 10% to 60% of bipolar patients may have a history of PD. The presence of PD (and other anxiety disorders) in bipolar patients is associated with a more pernicious and chronic course of the disorder, increased rates of alcohol and substance abuse, and increased rates of suicide. PD has also been associated with relatively high rates of alcohol and drug abuse, with a 24% lifetime rate of alcohol dependence reported in one naturalistic study of a clinical population of panic patients. Although patients with entrenched substance abuse require treatment targeted at this condition, treatment of the anxiety disorders in that context may facilitate the patients’ attempts to achieve and maintain sobriety.

PD is also associated with higher rates of somatization disorder, and patients with PD are at risk of excessively and repeatedly using medical facilities, including emergency rooms, primary care, and medical specialty services, seeking some explanation for their repeated volleys of autonomic arousal and other physical symptoms. In one study, the average patient with panic symptoms visited more than 10 physicians before receiving a diagnosis of PD. Patients with PD and elevated phobic anxiety appear to be at risk for premature death from cardiovascular causes. Although the mechanism for the increased mortality is unclear, attention has focused on the hypothesis that panic and phobic patients are at increased risk for the development of malignant arrhythmias because of decreased heart rate variability secondary to relatively increased sympathetic tone and decreased parasympathetic tone. In addition, PD appears to be increased in patients with a number of other medical complaints, including respiratory symptoms, irritable bowel and other gastrointestinal complaints, headaches, and dizziness, which often worsen the associated distress, dysfunction, and treatment response of these conditions.

Criteria for Remission

There are no universally accepted definitions for remission in PD or in other anxiety disorders, although definitions based on a series of consensus conferences have face validity and are useful in framing the issue. The importance of treating patients to remission in depression is established with the demonstration that patients with major depression experience incomplete functional recovery and increased risk of relapse and recurrence until they are treated to full resolution of their affective
symptomatology. It seems likely that treating anxiety disorder patients to remission will have similar salutary benefit.

Guidelines for remission in PD have been proposed and include resolution of symptoms in five domains: (1) freedom from panic attacks; (2) minimal or no agoraphobic avoidance; (3) reduction in free-floating anxiety to none or to minimal levels as operationalized by a Hamilton Rating Scale for Anxiety (HAM-A) score of ≤7–10; (4) no functional impairment, which has been operationalized as a score of ≤1 on each of the three items of the Sheehan Disability Scale assessing work, social, and family life; and (5) resolution of comorbid depression symptoms as evidenced by a 17-item Hamilton Rating Scale for Depression (HAM-D) score ≤7. An alternative definition for remission uses the clinician-rated Panic Disorder Severity Scale to assess frequency and severity of panic, agoraphobia, avoidance, anxiety, and functional impairment, and proposes a total score ≤3 and none of the seven individual items rated >1 (mild), along with remission of depressive symptomatology. At least part of the recent emphasis on the treatment of anxiety patients with antidepressants is motivated by the recognition of the high rates of depression in anxiety patients and the need to effectively treat the mood disorder in order to achieve remission.

Studies of outcome in the treatment of patients with PD have not generally applied the comprehensive criteria noted here. Many use panic-free status or improvement ratings. Controlled acute trials of benzodiazepines, tricyclic antidepressants, and selective serotonin reuptake inhibitors (SSRIs) suggest rates of panic attack resolution in the range of 50% to 70%. However, when more global measures of outcome are considered consistent with the consensus guidelines, fewer patients appear to achieve full remission. For instance, in a study of 176 PD patients with or without agoraphobia randomly assigned for 10 weeks of treatment with sertraline (50–200 mg/day) or placebo, panic-free rates at endpoint were 57% for the sertraline-treated patients versus 47% for placebo. Rates of remission were lower for both groups, but a significantly greater proportion of sertraline-treated patients (35%) achieved high end-state function compared with 19% of those taking placebo. High end-state function was used as a marker approximating remission in this study and was defined as a Clinical Global Impression–Severity Scale score of 1 or 2 (not ill or borderline ill) in conjunction with panic-free status for 2 weeks at endpoint.

Evaluation of longer-term outcome is often limited by methodological limitations of the studies, such as: inclusion only of patients who show acute response, dropouts, and lack of comprehensive remission criteria. The available data suggest that most patients who remain on active treatment maintain benefit or continue to improve. However,
the data also indicate that a substantial proportion of patients (40% or more) remain at least somewhat symptomatic.41

Social Phobia

Social phobia (sometimes referred to as social anxiety disorder) is characterized by a persistent fear of social or performance situations in which the individual is subject to the scrutiny of others and is concerned about acting in a way that is embarrassing or humiliating.6 Social phobia may be subtyped as either specific, which refers to difficulties with circumscribed situations or performance anxiety (eg, public speaking), or the often more chronic and disabling generalized subtype in which fears extend to most social situations.

Social phobia has a lifetime prevalence of approximately 13%, making it the third most common psychiatric disorder in the community after alcohol dependence and major depression. Social phobia has a typical age of onset in adolescence and in community samples is more prevalent in women than in men.42 The disorder has a typically chronic and unremitting course without treatment.43

Comorbidity

Social phobia tends to present comorbid with other anxiety disorders. In the National Comorbidity Survey (NCS), approximately 80% of individuals with social phobia had more than one psychiatric disorder.44 Because of its early age of onset, social phobia precedes other comorbid conditions in more than two thirds of patients.42 In a sample of more than 2,000 French patients, Lecrubier and Weiller45 reported that depression was the most common comorbid condition in social phobics, affecting more than 70% of these patients, with an onset age younger than 15 years. Clinical studies suggest that more than 40% of patients presenting for treatment of panic disorder also had social phobia.46 In one study of Vietnam veterans with PTSD, 30% had social phobia beginning after the development of PTSD.47 Alcohol abuse and dependence tend to be particularly high in patients with social phobia, presumably at least in part because alcohol is often ubiquitous in social situations and is relatively easily available as a maladaptive coping strategy.16 In the Epidemiologic Catchment Area study, individuals with social phobia had increased numbers of chronic medical disorders compared with those without social phobia.48 For instance, patients with Parkinson's disease have elevated rates of anxiety disorders in general, particularly social phobia.49 Social anxiety commonly occurs in the context of a number of medical disorders such as benign essential tremor, stuttering, irritable bowel syndrome, morbid obesity, and in burn victims.50,51
Fourth Edition, currently excludes social phobia due to medical disorders. From a clinical perspective, however, these individuals respond to treatments targeted at their social anxiety symptoms and they warrant treatment.

Social phobia is associated with significant negative impact on the quality of life of affected individuals, as evidenced by decreased educational attainment and occupational functioning, increased financial dependency, decreased likelihood of being married, and increased health care utilization.42,44,52

Remission

The most widely used measure for the assessment of social phobia is the Liebowitz Social Anxiety Scale (LSAS).53 It examines a relatively comprehensive group of situations that provoke social anxiety and rates both severity of fear/anxiety and frequency of avoidance. Severe scores on the LSAS are in the range of 80–120, moderate in the range of 60–80, and mild in the range of 40–60. Scores on the LSAS ≤30 are considered indicative of remission based in part on work demonstrating good separation of unaffected patients from those with social phobia by a score of 30.54 In addition, in order for patients to be considered fully remitted, they should have minimal to no anticipatory anxiety (HAM-A score ≤7–10), no appreciable functional impairment as indicated by a score of ≤1 on each item of the Sheehan Disability Scale, and no depressive symptoms as indicated by a score of ≤7 on the HAM-D.

There are few data addressing remission in treatment studies of social phobia. Most studies to date have reported on responder criteria defined by reduction in global severity of illness or specific social phobia measures like the LSAS. For instance, in a two-site study comparing cognitive behavioral group therapy (CBGT) to treatment with the monoamine oxidase inhibitor phenelzine for patients with social anxiety disorder, 58% of patients receiving CBGT and 65% of patients taking phenelzine were classified as responders (moderately or markedly improved) at 12 weeks in the intent-to-treat analysis.55 In another randomized controlled trial, 64% of treated patients were classified as responders to phenelzine.56 Controlled studies with the SSRIs in social phobia are consistent with these results. In a 12-week placebo-controlled, double-blind study with fluvoxamine, 43% of the fluvoxamine-treated patients versus 23% of those taking placebo were classified as responders.57 In a double-blind, placebo-controlled, flexible-dose, multicenter 20-week trial with sertraline in 204 patients with social phobia, Van Ameringen and colleagues58 reported that just over half (53%) of the patients given sertraline and 29% of patients receiving placebo were considered responders according to their Clinical Global Impression-
Improvement (CGI-I) scale scores at the end of treatment. In another double-blind, placebo-controlled, flexible-dose study of 187 patients, 55% of patients treated with paroxetine were rated much or very much improved after 12 weeks compared with 24% of patients treated with placebo. Results from a 12-week, fixed-dose study with paroxetine demonstrated response rates in the range of 40% to 50%.

Thus, in most studies examining the acute efficacy of pharmacotherapy as well as CBGT for social anxiety disorder, approximately 45% to 70% of patients were rated as responders. However, in most studies, responder criteria included patients who, though improved, were still symptomatic. For instance, in the fixed-dose paroxetine study, the proportion of patients who were “very much improved” and might be considered as closest to remitted ranged from 19% to 22%—less than half of the total responders. Thus, it appears that the majority of patients remain at least somewhat symptomatic and do not achieve remission after acute treatment.

**Posttraumatic Stress Disorder**

Individuals with PTSD have experienced or witnessed an event involving a significant threat of loss of life or severe harm to oneself, a loved one, or others, and have manifested an emotional response characterized by intense fear, helplessness, or horror. PTSD is comprised of symptoms from three domains, including: (1) reexperiencing phenomenon (eg, nightmares and flashbacks); (2) avoidance reactions (including thoughts, feelings, and activities associated with the trauma, as well as feelings of detachment or estrangement from others); and (3) high levels of autonomic arousal, including hypervigilance, difficulty sleeping, and irritability. Risk factors for the development of PTSD include trauma that is intense, proximal, and perceived to be uncontrollable, overwhelming, and life-threatening. The risk of developing trauma varies depending on the type of trauma to which individuals are exposed. For instance, the risk of PTSD is greater following exposure to assaultive violence compared with other types of trauma. Individual vulnerability factors are also likely pertinent, including prior mood and anxiety disorders, possible genetic or familial factors, autonomic dysregulation around the time of the trauma, and lower levels of social support and economic status.

The lifetime prevalence of PTSD is 7.8% according to the National Comorbidity Survey. In that study, men were more likely to experience a significant trauma (60.7%) compared with women (51.2%), although women were more than twice as likely to develop PTSD over their lifetime (10% versus 5%). Most respondents in the NCS who experienced trauma exposure reported more than one type of trauma. In a
study conducted in a community sample from the Detroit area, more than half of the PTSD cases in women were due to assault (including rape) compared with 15.4% in men. The sudden unexpected death of a loved one had a moderate probability of association with PTSD (14.3%), but due to its high rate of occurrence, it was the single most frequent precipitating event that both men (38.5%) and women (26.6%) reported in the study.

Comorbidity

According to the NCS, comorbidity in individuals with PTSD was common, occurring in 73% of individuals. PTSD patients were at increased risk for a number of mood and anxiety disorders, including first-onset major depression and alcohol abuse. Interestingly, it appears that the elevated risk for secondary disorders disappears when the PTSD remits, suggesting that the etiologic mechanism associating PTSD with the subsequent development of other disorders may be tied in many cases to the PTSD itself. PTSD is associated with significant impairment in quality of life and function, with one analysis documenting increased rates of work loss and work cutback days associated with PTSD similar to that for major depression. Roughly 3.6 days of work impairment per month are associated with PTSD, with an estimated $3 billion loss in annual productivity in the United States. Rates of attempted suicide among individuals with PTSD are also quite high (19% in one study) and are comparable to those reported for depression.

Remission

Recent recommendations for assessing remission in posttraumatic stress disorder include utilization of a comprehensive assessment tool, such as the Treatment Outcome PTSD Scale (TOPS-8). The TOPS-8 examines the full range of the PTSD symptom clusters: reexperiencing/intrusion, avoidance/numbing, and hyperarousal. A score of 7 on the TOPS-8 reflects mild symptoms and ≥21 signals more severe symptoms; a score of ≤5 reflects minimal PTSD symptoms and is consistent with remission. In addition, patients in remission should have minimal to no significant generalized anxiety (HAM-A score of ≤7–10), depression (HAM-D score of ≤7), or impairment (Sheehan Disability Scale score ≤1 on each item).

Treatment studies in PTSD often report outcome in terms of response rather than remission. For instance, in a 12-week, placebo-controlled trial of 187 patients, treatment with sertraline resulted in a responder rate of 53% at endpoint compared with 32% for placebo. Responder status was defined as a >30% reduction from baseline in the...
total severity score on the Clinician-Administered Posttraumatic Stress Disorder (CAPS-2) Scale and a CGI-I score of 1 (very much improved) or 2 (much improved). Recently, Davidson and colleagues reported pooled data from three placebo-controlled studies of paroxetine administered for up to 12 weeks for outpatients with chronic PTSD of moderately severe to severe intensity. For the purposes of these analyses, remission was defined as either a CAPS-2 total score of <20 or a Davidson Trauma Scale score of <18. Among patients treated with paroxetine, 31% achieved remission compared with 16% of placebo-treated patients. A similar relative proportion of patients achieved remission from depressive symptoms, suggesting that global symptom improvement was similar to the improvement for PTSD-specific symptoms, consistent with the definition of remission suggested by the consensus guidelines discussed here.

**Generalized Anxiety Disorder**

GAD is characterized by excessive anxiety and difficulty controlling worry about a number of events or activities, accompanied by symptoms of arousal and present most of the time for at least 6 months. The lifetime prevalence of GAD is 5%, with approximately 9 million affected Americans. GAD affects women more than men and its prevalence tends to increase with age. The typical age of onset is age 21 but is dependent on whether the GAD is primary, in which case the age of onset tends to be around age 13, or secondary to another anxiety disorder, in which the age of onset is later, around age 30.

**Comorbidity, Course, and Impairment**

GAD frequently occurs with other psychiatric disorders. The NCS reported that approximately 90% of GAD patients had a lifetime history of other comorbid psychiatric disorders, including major depression, dysthymia, panic disorder, bipolar disorder, and alcohol and substance abuse. Unipolar depression is the most common comorbidity, occurring in approximately two thirds of GAD patients.

The course of GAD appears to be chronic although fluctuating, and worsening during periods of stress. Many individuals with GAD, as with other anxiety disorders, have a significant history of anxiety dating back to childhood. Only about one third of GAD patients have spontaneous remission. In a naturalistic study of GAD patients treated before the widespread use of newer antidepressants and predominantly receiving benzodiazepines, only 25% achieved full remission after at least 2 years of treatment, a proportion that increased to only 38% after 5 years. In addition, risk of relapse after remission increases over time.
In one study, probability of relapse following response was 6% after 6 months, 20% after 2 years, and 28% after 5 years.\(^{81}\)

Even in the absence of comorbid conditions, GAD is associated with significant distress and impairment.\(^{84}\) For instance, in a study by Kessler and colleagues,\(^{85}\) GAD alone was associated with marked impairment comparable to that caused by major depression; patients with comorbid depression and GAD had even greater degrees of disability. GAD with comorbid psychiatric disorders is associated with higher total costs, including those secondary to increased emergency room utilization, medical hospitalizations, laboratory testing, specialty medical services, and medication use, in addition to indirect costs associated with decreased productivity.\(^{4,86}\)

**Remission**

For patients with comorbid GAD and depression, GAD typically begins first, raising the possibility that aggressive treatment of GAD may attenuate or prevent progression of the disorder to the more severe comorbid states.\(^{82}\) Recent recommendations for the definition of remission in GAD\(^5\) require a HAM-A score \(\leq 7\) (or a reduction of at least 70% in baseline levels of symptoms), as well as elimination of depression as indicated by a HAM-D score of \(\leq 7\), prevention of its recurrence, and resolution of functional impairment as indicated by a score of \(\leq 1\) on each item of the Sheehan Disability Scale.

One study examining outcome in 324 patients randomized to treatment with paroxetine or placebo for 8 weeks reported remission rates of 36% for the last observation carried forward population and 42.5% for completers on paroxetine. These rates are in comparison to 22.7% and 26.5%, respectively, on placebo.\(^{87}\) Remission in this study was defined as a HAM-A score \(\leq 7\).

Emerging data suggest that improvement continues over time in patients being treated for GAD, and that a longer duration of treatment may be necessary in order to achieve remission, particularly for patients with more severe levels of anxiety. For instance, in a study pooling data from two double-blind, placebo-controlled 6-month trials of venlafaxine extended release (XR), relative changes in the percentage of responders and remitters at week 8 and month 6 for the venlafaxine- and placebo-treated patients were analyzed.\(^{88}\) Rates of responders (HAM-A \(\geq 50\%\) improvement) and remitters (HAM-A \(\leq 7\)) were significantly greater at both time points for the venlafaxine group compared with placebo-treated patients. Rates of response to venlafaxine at week 8 and month 6 was 58% and 66% respectively, compared with 36% and 39% at the same time points for placebo. Similarly, remission rates at week 8 and month 6 for venlafaxine were 32% and 43%, respectively, compared
with 15% and 19% at the same time points for placebo. Thus there was a significant increase in the number of responders and remitters over time for venlafaxine though not for placebo. In addition, close to two thirds (64%) of nonresponders to venlafaxine at 8 weeks became responders by 6 months compared with only 26% of those in the placebo group. Further, of patients who had been responders to venlafaxine by week 8, 61% had progressed to remission by 6 months compared with only 39% of the placebo-treated group.

The impact of longer duration of treatment may be particularly important for more severely ill patients. In this study, rates of remission at week 8 were lower for patients with baseline severe anxiety (HAM-A >25) compared with those with moderate anxiety (HAM-A ≤25) in both the venlafaxine-treated (29% versus 35%, respectively) and placebo-treated patients (9% versus 20%). However, by 6 months, whereas placebo-treated patients with severe anxiety continued to experience lower remission rates (15%) compared with those with moderate anxiety (23%), patients treated with venlafaxine XR achieved similar rates of remission (43%) regardless of initial severity. This underscores the importance of longer treatment in promoting continued improvement and achievement of remission.

**Conclusion**

The anxiety disorders, including PD, social phobia, PTSD, and GAD, are highly prevalent and associated with marked symptomatic distress and dysfunction. The associated high rates of comorbidity with other anxiety disorders, mood disorders, and alcohol and substance abuse increases the morbid burden of these conditions. Increased attention, both in research and in practice settings, to the importance of targeting remission as a critically important, clinically meaningful outcome measure, coupled with the continued development of better tolerated and more effective treatment strategies hold the promise of improved treatment for patients suffering from anxiety disorders.

**References**

NEW ADVANCES IN THE MANAGEMENT OF ANXIETY


NEW ADVANCES IN THE MANAGEMENT OF ANXIETY


NEW ADVANCES IN THE MANAGEMENT OF ANXIETY


