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Drug Effectiveness and Tolerability in Anxiety Disorders: A Review

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Abstract— Anxiety disorders are among the most common psychiatric conditions, significantly impairing quality of life and functioning, with their rising prevalence posing a major challenge to healthcare systems. This review summarizes current evidence-based pharmacological strategies, focusing on the efficacy and tolerability of the most widely used agents, including selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), pregabalin, benzodiazepines, buspirone, and tricyclic antidepressants (TCAs). Meta-analyses indicate SSRIs and SNRIs as first-line therapies across anxiety disorders, while pregabalin demonstrates favourable outcomes in generalized anxiety disorder. Benzodiazepines, though effective for rapid symptom relief in panic disorder, remain limited by their dependence potential. Effective management requires an individualized approach that integrates pharmacotherapy with psychotherapy, balancing drug efficacy, safety, and patient preferences to optimize long-term outcomes.

Keywords— Anxiety disorders, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, treatment efficacy, generalized anxiety disorders

1. INTRODUCTION

Anxiety disorders are among the most frequently diagnosed mental health conditions, both in the general population and in clinical practice. According to the World Health Organization (WHO), in 2019, approximately 301 million people worldwide were affected by these disorders, accounting for nearly 4% of the global population [1]. This represents a significant public health concern that impacts not only individuals but also healthcare systems and societies as a whole. Symptoms most commonly emerge in early adulthood or adolescence, and women are almost twice as likely to be affected as men [2]. Clinical reviews indicate that the presence of anxiety disorders significantly increases the risk of developing other mental health conditions, including additional anxiety disorders, mood disorders, and substance use disorders [3]. According to research by Yang X. et al. [4], since 1990 the number of anxiety disorder cases has increased by over 50%, while the age-standardized rate has remained relatively stable, which may reflect improved recognition and diagnostic availability.

Anxiety disorders differ from natural fear or anxiety responses in that their symptoms are excessive, persistent, and significantly interfere with daily functioning. Anxiety is defined as excessive worry and a chronic sense of unease occurring on most days for at least six months, typically concerning various life situations such as work or academic performance. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [5], the anxiety disorder category includes separation anxiety disorder, selective mutism, social anxiety disorder, panic disorder, agoraphobia, specific phobias, and generalized anxiety disorder. Patients with anxiety disorders frequently report comorbid somatic symptoms, such as sleep disturbances, headaches, low mood, as well as gastrointestinal and cardiovascular

complaints [2]. Untreated anxiety disorders carry serious consequences on both individual and societal levels, including increased use of primary and emergency healthcare services, reduced work productivity, a higher risk of unemployment, and impaired interpersonal relationships [3].

Contemporary approaches to treating anxiety disorders emphasize personalized, evidence-based (EBM) interventions that consider patient preferences, clinical course, comorbidities, and the adverse effect profile. Research shows that higher symptom severity is associated with a lower quality of life (QOL); however, the effectiveness of current treatment options - both pharmacological and psychological - is estimated to range between 60% and 85%. Interventions such as cognitive-behavioral therapy (CBT) have been shown to significantly improve functioning and well-being in affected individuals [6,7]. In this article, we will present several selected medications from pharmacological groups used in the treatment of anxiety disorders, and then focus on a detailed analysis of their efficacy and tolerability.

2. PHARMACOLOGICAL TREATMENT

A. Selective serotonin reuptake inhibitor (SSRI)

1) ***Paroxetine:*** Paroxetine is a selective serotonin reuptake inhibitor that acts by blocking the serotonin transporter (SERT), thereby increasing the concentration of serotonin in the synaptic cleft [8]. The elevated synaptic serotonin levels contribute to the downregulation of previously upregulated serotonergic receptors, restoring neurotransmitter balance within the central nervous system [8]. The drug is available in immediate-release and controlled-release tablet formulations, as well as an oral suspension, and is indicated for the treatment of depression, generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder (PD), post-traumatic stress disorder (PTSD), and social anxiety disorder (SAD) [9]. The typical adult daily dosage ranges from 10 to 60 mg, with a recommended maximum of 40 mg in elderly patients [9]. Paroxetine demonstrates good oral bioavailability, reaching peak plasma concentrations within 5-8 hours post-administration. Steady-state levels are usually achieved within 7-14 days of daily dosing [9]. In addition to its primary mechanism of action, paroxetine exhibits affinity for several other receptor types, including muscarinic, adrenergic (α and β), dopaminergic (D2), serotonergic (5-HT2), and histaminergic (H1) receptors, which may explain some of its side effects [10]. The most commonly reported adverse effects include nausea, dry mouth, somnolence, excessive sweating, sexual dysfunction, reduced appetite, and constipation [9]. Importantly, paroxetine is associated with a higher incidence of discontinuation syndrome compared to other SSRIs [11]. Symptoms - such as dizziness, nausea, insomnia, irritability, flu-like symptoms, and anxiety - typically begin within 24 to 48 hours following abrupt cessation, peak around day five, and resolve within two to three weeks [12]. The severity of symptoms depends on the daily dose and duration of treatment [12].

2) ***Escitalopram:*** Escitalopram, the active S-enantiomer of citalopram, is a selective serotonin reuptake inhibitor characterized by its high selectivity and strong affinity for the serotonin transporter, while exerting minimal influence on other neurotransmitter receptors, including dopaminergic, adrenergic, histaminergic, and muscarinic systems [13,14,15]. This pharmacological profile contributes to its favourable safety and tolerability. Its mechanism of action involves the inhibition of serotonin reuptake in synaptic clefts, leading to increased serotonergic neurotransmission within the central nervous system [13,15]. The efficacy of escitalopram has been well-documented in clinical trials involving patients with generalized anxiety disorder (GAD), social anxiety disorder (SAD), and panic disorder (PD), demonstrating significant symptom reduction and improved functional outcomes compared to placebo [13]. Following oral administration, escitalopram reaches peak plasma concentrations within 3-5 hours, with steady-state levels typically achieved within 1-2 weeks [14,15]. Treatment usually begins at a dose of 10 mg per day, with the option to increase to 20 mg based on individual clinical response [13,15]. The most common side effects include nausea, ejaculation disorders, insomnia, diarrhea, drowsiness, and dizziness, though these are generally mild and infrequently lead to treatment discontinuation [16].

3) ***Sertraline:*** Sertraline is one of the most commonly used SSRIs, especially in the treatment of anxiety and depressive disorders. Its efficacy has been confirmed in numerous studies - both in short-term and long-term therapy - for conditions such as generalized anxiety disorder (GAD), panic disorder (PD), social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD), including in children and adolescents [17,18,19]. Sertraline works by selectively inhibiting the reuptake of serotonin in the central nervous system, increasing its availability in synaptic clefts [19,20]. Compared to other SSRIs, it shows slightly greater dopaminergic activity, although this is not considered to have major therapeutic relevance [20,21]. Sertraline is slowly absorbed, with peak plasma concentrations typically occurring 4 to 10 hours after oral administration. Its half-life ranges from 24 to 32 hours, which allows for convenient once-daily dosing [18,20]. For PTSD, PD, and SAD, treatment usually starts at 25 mg per day, with weekly dose increases of 50 mg, up to a maximum of 200 mg daily [21]. Sertraline is generally well tolerated. The most commonly reported side effects include nausea, headache,

drowsiness, dry mouth, excessive sweating, as well as gastrointestinal and sexual dysfunction [19,21]. Less frequently, more serious adverse effects may occur, such as mania activation, serotonin syndrome, seizures, hypersensitivity reactions, or withdrawal symptoms. It is also important to note that using sertraline during the first trimester of pregnancy may increase the risk of congenital heart defects in the fetus [21].

4) ***Fluoxetine****:* Fluoxetine is one of the most extensively studied and widely prescribed selective serotonin reuptake inhibitors, considered a first-line treatment for depression and anxiety disorders, including in children and adolescents [22,23,24]. It is also approved for obsessive-compulsive disorder (OCD), bulimia nervosa, premenstrual dysphoric disorder (PMDD), and panic disorder (PD) [22,24]. Fluoxetine selectively inhibits serotonin reuptake, increasing its synaptic availability and enhancing serotonergic neurotransmission [23,25]. Due to its low affinity for adrenergic, histaminergic, and muscarinic receptors, it causes fewer cardiovascular and anticholinergic side effects compared to tricyclic antidepressants [23]. Pharmacokinetically, fluoxetine is well absorbed, reaches peak plasma concentration within 6–8 hours, and has a long half-life - ranging from 1 to 4 days for fluoxetine itself and 7 to 10 days for its active metabolite, norfluoxetine. This allows for once-daily dosing and a gradual washout after discontinuation [24,25]. In younger populations, especially when combined with cognitive-behavioral therapy (CBT), fluoxetine is effective and generally well tolerated [23]. To achieve therapeutic efficacy in most patients, a daily dose ranging from 20 to 40 mg is usually required [26]. The most common adverse effects include dry mouth, nausea, diarrhea, headache, insomnia, and constipation [25,26].

5) ***Fluvoxamine****:* Fluvoxamine is one of the most thoroughly studied and longest-used selective serotonin reuptake inhibitors, available in clinical use since 1983 [27]. Initially approved for the treatment of obsessive-compulsive disorder (OCD), its clinical applications have since expanded to include panic disorder (PD), social anxiety disorder (SAD), and a range of obsessive-compulsive spectrum disorders (OCD) - such as trichotillomania, pathological gambling, body dysmorphic disorder, and compulsive buying [27,28]. Its mechanism of action is based on the selective inhibition of the serotonin transporter, leading to increased synaptic availability of serotonin and enhanced serotonergic neurotransmission in brain regions responsible for the regulation of mood and anxiety [27,29]. Pharmacokinetically, fluvoxamine is almost completely absorbed from the gastrointestinal tract, reaching peak plasma concentrations within 2-8 hours, regardless of food intake [28]. Importantly, fluvoxamine exhibits minimal affinity for cholinergic, histaminergic, or dopaminergic receptors, contributing to its favourable safety profile [29]. The efficacy of fluvoxamine in the treatment of OCD has been confirmed in randomized controlled trials, with doses of 100-300 mg/day administered over 6-10 weeks significantly reducing symptom severity compared to placebo [28]. Among adverse effects, nausea is the most frequently reported, while other effects such as somnolence, asthenia, dry mouth, and insomnia occur less commonly [27,28]. Clinically, fluvoxamine is generally well tolerated, particularly in elderly patients and those with mild cardiovascular disease, in whom medications with anticholinergic or cardiotoxic properties should be avoided [28]. According to current treatment guidelines, SSRIs - fluvoxamine included - remain the first-line pharmacological option for OCD. To properly evaluate therapeutic efficacy, the medication should be administered in an adequate dose for at least 12 weeks [30].

B. Serotonin and norepinephrine reuptake inhibitor (SNRI)

1) ***Venlafaxine***: Venlafaxine is an antidepressant drug classified as a serotonin-norepinephrine reuptake inhibitor. It has been approved for the treatment of major depressive disorder, generalized anxiety disorder (GAD), panic disorder (PD), and social anxiety disorder (SAD) [31]. Its mechanism of action involves inhibition of serotonin (5-HT) and norepinephrine (NE) reuptake, with noradrenergic effects becoming more pronounced at higher doses [32]. Its active metabolite, O-desmethylvenlafaxine, also inhibits the reuptake of both neurotransmitters, showing greater affinity for the norepinephrine transporter [31,33]. Venlafaxine is well absorbed from the gastrointestinal tract, with at least 92% of the administered dose being absorbed orally and an absolute bioavailability of approximately 45% [33]. In addition to its primary mechanism, the drug may also partially influence dopamine reuptake, which may contribute to its antidepressant effects [33]. The side effect profile of venlafaxine is dose-dependent - at lower doses, adverse effects are similar to those observed with SSRIs and include nausea, vomiting, gastrointestinal disturbances, and sexual dysfunction [32]. At higher doses, patients may experience side effects typical of noradrenergic activation, such as dry mouth, excessive sweating, tachycardia, and increased blood pressure [32]. Meta-analyses have also shown an increased risk of mild adverse effects, including dizziness, drowsiness, insomnia, tremor, asthenia, and decreased appetite [34].

2) ***Duloxetine****:* Duloxetine, a selective serotonin and norepinephrine reuptake inhibitor, demonstrates robust efficacy in the treatment of both psychiatric and pain-related conditions. Clinically, it is indicated for major depressive disorder (MDD), generalized anxiety disorder (GAD), diabetic neuropathic pain, fibromyalgia, and chronic musculoskeletal pain [35,36]. Its mechanism of action is primarily based on the inhibition of serotonin (5-HT) and norepinephrine (NE) reuptake in the central nervous system, while it shows minimal affinity for muscarinic, histaminergic, adrenergic, dopaminergic, serotonergic, and opioid receptors [35,36,37]. Oral bioavailability ranges from 32% to 80%, and the drug has a mean elimination half-life of approximately 12 hours. Duloxetine undergoes extensive hepatic metabolism and, importantly, does not inhibit monoamine

oxidase activity [35,36]. Regarding safety, duloxetine is generally well tolerated, with its adverse effect profile reflecting its pharmacological properties and predominantly involving the gastrointestinal and nervous systems [38]. The most frequently reported side effects include nausea, dry mouth, headache, dizziness, fatigue, and reduced appetite [36,39]. Despite these, duloxetine is considered a safe and effective therapeutic option, supported by a solid body of clinical evidence across a broad range of psychiatric and neurologic indications [38].

C. ***Pregabalin***

Pregabalin is a pharmacological agent with a unique mechanism of action, distinct from that of classical anxiolytics. Despite its structural similarity to gamma-aminobutyric acid (GABA), pregabalin is neither converted into GABA nor does it bind to GABA-A or GABA-B receptors, thereby excluding direct GABAergic involvement in its clinical effects [40,41]. Its therapeutic action is primarily mediated through high-affinity binding to the α2-δ auxiliary subunit of voltage-gated calcium channels located on presynaptic neurons. This binding modulates calcium influx and reduces the release of excitatory neurotransmitters such as glutamate and substance P, which underlies its anxiolytic, antiepileptic, and analgesic properties [40,41,42]. Pregabalin is rapidly absorbed after oral administration, with peak plasma concentrations typically reached within approximately one hour under fasting conditions. It exhibits high bioavailability independent of the administered dose. Since pregabalin is eliminated almost exclusively unchanged via renal excretion, dose adjustments are required in patients with impaired renal function [41]. Within the European Union, pregabalin is approved for the treatment of generalized anxiety disorder (GAD), peripheral and central neuropathic pain, and as adjunctive therapy in partial-onset seizures [42]. Clinical trials have demonstrated good tolerability of pregabalin at therapeutic doses ranging from 150 to 600 mg per day. The most frequently reported adverse effects include dizziness and somnolence, while less common side effects involve ataxia, paresthesias, concentration difficulties, increased appetite, and weight gain [42]. Due to its favorable pharmacological profile and well-established efficacy, pregabalin is also utilized in off-label indications, including the management of acute anxiety states such as preoperative anxiety [43].

D. ***Benzodiazepines (BZDs)***

Benzodiazepines represent an important pharmacological group used in the treatment of anxiety disorders - particularly during the initial phase of therapy, when rapid symptom relief is needed, or as short-term, adjunctive treatment. Their mechanism of action involves allosteric binding to the GABA-A receptor, enhancing chloride ion influx into neurons. This results in hyperpolarization of the neuronal membrane and reduced excitability, which underlies their anxiolytic, sedative, and muscle-relaxant effects [44].

Among the most commonly used benzodiazepines in anxiety management are diazepam, lorazepam, and alprazolam. Diazepam, one of the earliest and most extensively studied benzodiazepines, exerts anxiolytic, anticonvulsant, and muscle-relaxant effects, making it useful not only in anxiety disorders but also in managing spasticity, epilepsy, and alcohol withdrawal symptoms [44]. Lorazepam is characterized by its rapid onset of action and intermediate half-life, which makes it a preferred agent in inpatient settings - for example, in acute anxiety episodes or as premedication before procedures [45]. Alprazolam, one of the most frequently prescribed psychotropic medications in the United States, is primarily used for generalized anxiety disorder (GAD) and panic disorder (PD). However, it carries a high risk of dependence and is associated with a particularly severe withdrawal syndrome, even when discontinued gradually according to prescribing guidelines [46].

Despite their clinical effectiveness, benzodiazepines are not without limitations. Common adverse effects include drowsiness, anterograde amnesia, dizziness, impaired coordination, and an increased risk of falls - particularly among older adults [47]. Due to the risks of tolerance, dependence, and cognitive side effects, long-term use is generally discouraged. Instead, benzodiazepines are typically recommended for short-term use, ideally as a bridge during the initiation phase of antidepressant treatment, which often

requires several weeks to exert full anxiolytic effects. Importantly, their euphoric potential - especially when combined with opioids or stimulants - can significantly increase the risk of substance use disorders and overdose-related mortality [48].

E. ***Buspirone***

Buspirone is an anxiolytic from the azapirone class, distinguished by a unique pharmacological profile that differs from traditional benzodiazepines. Although initially developed as a potential antipsychotic targeting dopamine D2 receptors, it soon became clear that its primary clinical use lies in the treatment of anxiety disorders - particularly generalized anxiety disorder (GAD) - where it demonstrates efficacy comparable to that of benzodiazepines such as diazepam, lorazepam, or alprazolam [49,50]. Buspirone's mechanism of action is primarily based on its affinity for serotonin 5-HT1A receptors - it acts as a full presynaptic agonist in the raphe nuclei and a partial postsynaptic agonist in the hippocampus [49,51,52]. It also shows moderate affinity for dopamine D2 receptors and a mild effect on 5-HT2 and α1-adrenergic receptors [49,51,53]. Importantly, unlike benzodiazepines, it does not act on the GABA-A receptor complex, thus avoiding the risk of dependence, sedation, or cognitive impairment [49,52,53]. Buspirone is rapidly absorbed, reaching peak plasma concentration within 40-90 minutes; however, due to significant first-pass metabolism, its oral bioavailability is only about 4% [50,51]. Treatment typically begins at 15 mg per day, with dose increases of 5 mg every 2-3 days until the desired therapeutic effect is achieved, not exceeding a maximum of 60 mg per day [50]. Buspirone is generally well tolerated. The most commonly reported adverse effects include dizziness, headache, nausea, light-headedness, nervousness, and dry mouth; gastrointestinal symptoms are less frequently observed [51,53].

F. ***Tricyclic Antidepressants (TCAs)***

Based on the available data, tricyclic antidepressants (TCAs) may represent an effective therapeutic option in the treatment of anxiety disorders, including generalized anxiety disorder (GAD), panic disorder (PD), and obsessive-compulsive disorder (OCD) [54,55,56,57]. Their mechanism of action is primarily based on the inhibition of serotonin and norepinephrine reuptake, as well as interactions with cholinergic, adrenergic, and histaminergic receptors, which accounts for their broad pharmacological activity [54,57]. Among this group, imipramine and clomipramine have been the most thoroughly studied - particularly the latter, which demonstrates high efficacy in the treatment of OCD and is FDA-approved for use in individuals aged 10 and older [54,55,56,57]. At the same time, it is important to recognize the numerous limitations associated with TCA therapy. These medications carry a significant risk of adverse effects, such as dry mouth, drowsiness, weight gain, orthostatic hypotension, and sexual dysfunction, which stem from their non-selective receptor profile [54,55]. Moreover, TCAs have a narrow therapeutic index—overdose can lead to severe cardiac arrhythmias, coma, or even death, which is particularly relevant in patients with comorbid depression and increased suicide risk [54,55,56].

3. COMPARISON OF DRUG EFFECTIVENESS AND TOLERABILITY

In recent years, several important meta-analyses have been published that allow for a more precise comparison of the efficacy and tolerability profiles of pharmacological treatments for anxiety disorders. These findings are particularly useful in clinical practice, as they consider both therapeutic effects and adverse events, which can significantly impact patient adherence.

One of the most important reviews in this area is a large network meta-analysis by Gosmann et al. (2023) [58] examined data from 80 randomized controlled trials, involving a total of 21,338 participants. The analysis focused on the incidence of adverse effects associated with SSRIs and SNRIs used in the treatment of anxiety, obsessive-compulsive, and stress-related disorders. Nausea was the most frequently

reported side effect (25.71%, 95% CI 23.96-27.54), while weight changes were among the least frequent (3.56%, 95% CI 1.68-7.37). Interestingly, sertraline and fluoxetine did not differ significantly from placebo in the overall frequency of adverse effects, whereas other drugs were associated with higher rates of side effects. A strong nocebo effect was also observed - 71.21% (95% CI 67.00–75.09) of patients receiving placebo reported adverse symptoms. The authors emphasized that patient education and transparent communication may be crucial for improving adherence and reducing treatment dropout. Escitalopram and sertraline emerged as the best-tolerated options, while paroxetine, venlafaxine, and duloxetine had the highest rates of adverse effects.

Further valuable data come from a 2019 meta-analysis by He. et al. [59], which evaluated the efficacy and tolerability of eight drugs in patients with generalized anxiety disorder (GAD). This review included 41 studies with a total of 15,739 participants. In terms of efficacy, all medications except fluoxetine and vortioxetine outperformed placebo, with escitalopram showing the greatest reduction in HAM-A scores (MD = -3.2, 95% CrI -4.2 to -2.2). Venlafaxine had the highest clinical response rate (OR = 2.2, 95% CrI 1.8-2.8), whereas paroxetine showed the lowest (OR = 1.6, 95% CrI 1.1-2.4). From a tolerability standpoint, vilazodone stood out due to higher rates of side effects (OR = 1.7, 95% CrI 1.1-2.7) and treatment discontinuation. Interestingly, although vortioxetine was less effective, it demonstrated a more favorable tolerability profile than many other agents. These findings support current clinical guidelines recommending SSRIs and SNRIs - particularly escitalopram, venlafaxine, and duloxetine - as first-line treatments for GAD.

In addition to classical SSRIs and SNRIs, increasing attention has been paid to the alternative anxiolytics, such as pregabalin. In a 2025 meta-analysis by Cardoner et al. [60], the efficacy and safety of pregabalin were assessed across 14 randomized trials including 4,822 adult patients with GAD. Significant symptom reduction on the Hamilton Anxiety Rating Scale (HAM-A) was observed as early as two weeks into treatment (MD = -1.23, 95% CI -1.79 to -0.66), with increasing effect over time. Pregabalin also outperformed placebo in terms of clinical response (OR = 1.51, 95% CI 1.31-1.75) and physician-rated improvement on the Clinical Global Impression-Improvement Scale (CGI-I). The drug was well tolerated, with lower treatment discontinuation rates and no significant increase in adverse effects compared to placebo. Although pregabalin is more expensive than SSRIs, its use was associated with a small but meaningful gain in quality-adjusted life years (QALYs). This makes it a viable option for patients with GAD who either poorly tolerate SSRIs or require a faster onset of action.

Finally, with regard to panic disorder, important findings were reported in a 2023 network meta-analysis by Guaiana et al [61]. The aim was to assess the efficacy and acceptability of various antidepressants and benzodiazepines in the acute treatment of panic disorder, with or without agoraphobia, using a network meta-analysis comparing these medications with placebo. The analysis of 48 randomized clinical trials involving 10,118 patients showed that most medications were more effective than placebo in achieving clinical response. The strongest effects were observed for benzodiazepines, specifically diazepam (RR = 0.65, 95% CrI 0.28-0.96), alprazolam (RR = 0.68, 95% CrI 0.39-0.92), and clonazepam (RR = 0.71, 95% CrI 0.41-0.94). Efficacy has also been demonstrated for other medications, such as paroxetine, venlafaxine, clomipramine, escitalopram, imipramine, fluvoxamine, citalopram, and sertraline. A treatment acceptability analysis, based on 64 studies with 12,310 participants, showed that alprazolam (RR = 0.46, 95% CrI 0.33-0.65) and diazepam (RR = 0.50, 95% CrI 0.23-0.91) were associated with lower rates of treatment discontinuation compared with placebo, whereas buspirone (RR = 1.83, 95% CrI 1.14-3.34) was associated with the highest rate of treatment discontinuation. With respect to symptom remission (32 studies, n = 8569), the most effective medications were desipramine (RR = 0.66, 95% CrI 0.29-0.97) and alprazolam (RR = 0.65, 95% CrI 0.44-0.84). With respect to agoraphobic symptoms (26 studies, n = 7044), the greatest efficacy was observed for citalopram (SMD = -0.87, 95% CrI -1.32 to -0.41) and reboxetine (SMD = -0.86, 95% CrI -1.62 to -0.11). These results indicate that both benzodiazepines and some antidepressants may be effective in the treatment of panic disorder.

4. CONCLUSIONS

Anxiety disorders represent a heterogeneous group of mental health conditions that - although often underestimated - can significantly impair daily functioning, affecting not only psychological well-being but also somatic health. Modern pharmacotherapy provides us with several effective treatment options, and based on current meta-analyses, SSRIs and SNRIs remain the most commonly recommended drug classes due to their well-established efficacy and relatively good tolerability. Medications such as escitalopram, venlafaxine, and duloxetine show a clear advantage over placebo and continue to serve as first-line treatments, particularly in generalized anxiety disorder (GAD), but also in social anxiety disorder and panic disorder. Pregabalin represents a promising alternative as it rapidly and sustainably reduces symptom severity, is well tolerated, and positively impacts quality of life, making it suitable for patients who do not tolerate SSRIs or require a fast-acting medication.

However, choosing the right medication should not rely solely on population-level data - individualization of treatment is crucial and involves not only assessing the efficacy of a given drug but also considering its side effect profile, the patient's expectations, previous treatment experiences, and even lifestyle. In clinical practice, careful listening, readiness to adapt the treatment plan, and open, collaborative communication with the patient are essential for building trust and improving adherence. It's also important to remember that even the best-chosen pharmacological treatment should not exclude psychotherapy, which - especially in the cognitive-behavioral approach - can serve as an equally effective or even standalone intervention.

Therefore, when thinking about treating anxiety disorders, we should avoid rigid protocols - true treatment success lies not only in prescribing the right medication but in a comprehensive, personalized approach to the individual behind the diagnosis.

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