

What Is Anxiety? A Clinical and Communication-Oriented Review

Christian Jonathan Haverkamp

Narrative Clinical Review

Abstract—Anxiety is an adaptive response to possible threat, but it becomes clinically important when it is persistent, disproportionate, inflexible, distressing, or impairing. This narrative clinical review integrates diagnostic guidance, cognitive-behavioral evidence, affective neuroscience, and a communication-oriented formulation. Anxiety is best understood as a coordinated multilevel process involving anticipation, attention, interpretation, bodily arousal, action tendencies, avoidance, and interpersonal signaling rather than as a single feeling or brain circuit. Assessment should distinguish ordinary alarm from an anxiety disorder and examine time course, triggers, function, medical and substance contributors, comorbidity, realistic danger, and the consequences of coping responses. Avoidance, checking, and reassurance often bring short-term relief while restricting corrective learning and valued activity. Treatment should follow the diagnosis, evidence, risk, and patient preference. Psychoeducation, exposure-based cognitive-behavioral methods, selected medication, and attention to sleep, substances, relationships, and social conditions may all have a role. A communication-focused perspective can supplement established care by clarifying which internal or interpersonal signals are difficult to recognize, express, test, or revise. Clinicians should communicate diagnostic uncertainty plainly and formulate care collaboratively. The therapeutic aim is not to eliminate all alarm, but to help the patient respond more flexibly, protect against genuine danger, and return to meaningful action.

Index Terms—anxiety, fear, threat, uncertainty, avoidance, communication, psychotherapy, assessment

I. INTRODUCTION

Anxiety belongs to ordinary life. It mobilizes attention before an examination, heightens vigilance on an unfamiliar street at night, and encourages preparation when an outcome matters. Yet anxiety can also become a source of sustained suffering: a person may spend hours worrying, avoid

work or relationships, interpret bodily sensations catastrophically, or organize a life around preventing events that are unlikely to occur. The word therefore names both an adaptive capacity and a family of clinical problems. A useful definition must preserve that distinction without implying that a precise boundary exists in every case. Earlier JPPC discussions emphasized anxiety as an adaptive emotion that may become debilitating and highlighted the roles of avoidance, interpretation, uncertainty, and communication (Haverkamp, 2012; Haverkamp, 2017a, 2017b). The present review places those themes alongside contemporary diagnostic and empirical accounts.

Everyday language also blurs anxiety with fear, stress, worry, panic, nervousness, and dread. These states overlap, but they are not synonyms. Fear usually refers to an immediate or identifiable threat, whereas anxiety more often concerns possible future harm. Worry is a predominantly verbal chain of thought used to anticipate or control uncertainty. A panic attack is an abrupt surge of intense fear or discomfort with characteristic physical and cognitive symptoms. Stress refers to demands on adaptation and the responses they evoke. Any of these can occur without a disorder, and an anxiety disorder can include several of them. Diagnostic systems organize syndromes; they do not exhaust lived experience (American Psychiatric Association, 2022; World Health Organization, 2022).

Core propositions

- Anxiety is a coordinated response to possible threat, not a single feeling or a single brain circuit.
- Clinical significance depends on persistence, disproportionality, inflexibility, distress, impairment, and context.
- Avoidance and safety behavior can reduce distress now while maintaining anxiety later.
- A symptom score is useful for monitoring but cannot replace diagnostic, medical, developmental, and functional assessment.
- Treatment should reflect the presentation, maintaining processes, preferences, and safety.

Christian Jonathan Haverkamp, M.D., LL.M., is a psychotherapist in private practice in Dublin, Ireland. Correspondence: jonathanhaverkamp@gmail.com. Website: www.jonathanhaverkamp.com. © 2022 Christian Jonathan Haverkamp.

II. SCOPE AND METHOD

This article is a narrative clinical review rather than a systematic review or treatment guideline. Literature searches were conducted for English-language diagnostic guidance, clinical guidelines, systematic reviews, meta-analyses, and influential original or theoretical papers available through 30 November 2022. Search concepts included anxiety, fear, threat, uncertainty, interoception, attention bias, avoidance, safety behavior, impairment, assessment, exposure, cognitive-behavioral therapy, pharmacotherapy, communication, and psychotherapy. Priority was given to DSM-5-TR and ICD-11, NICE guidance, high-quality syntheses, and papers that clarify mechanisms without treating any single model as settled fact. Earlier JPPC articles were reviewed in full before citation. Because this is a conceptual synthesis, mechanistic claims are framed as provisional and should not be interpreted as establishing a unique cause in an individual patient. Tables 1–5 and the shaded clinical boxes are author-developed syntheses, not validated instruments.

III. AN ADAPTIVE STATE AND A CLINICAL PROBLEM

Adaptive anxiety anticipates possible danger. It directs attention toward uncertainty, adverse outcomes, and preparation before a threat is established. This bias is valuable because waiting for certainty may be too late, but it also produces false alarms. A highly sensitive smoke detector is irritating during cooking, whereas insensitivity would be dangerous in a fire. The analogy is incomplete—people interpret, remember, communicate, and learn in ways smoke detectors do not—but it shows why anxiety cannot simply be removed without losing a protective function.

Clinical anxiety is not defined by intensity alone. A brief, intense response may be proportionate to danger, while a lower but continuous level may erode sleep, concentration, relationships, and health. Diagnostic judgments consider duration, breadth, controllability, distress, avoidance, and functional impairment. Generalized anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobia, and separation anxiety disorder are classified separately because their central fears, course, and effective interventions differ (American Psychiatric Association, 2022; World Health Organization, 2022). Obsessive-compulsive disorder and post-traumatic stress disorder are clinically related but occupy separate diagnostic groupings. The distinction matters when selecting treatment.

Epidemiological research shows that anxiety disorders are common, frequently begin early, and often co-occur with other mental disorders (Kessler et al., 2005; Craske et al., 2017). Prevalence figures depend on definitions, instruments, age, culture, and period of observation, so a single number should not be treated as timeless. More important clinically, common

does not mean trivial. Anxiety can impair education, employment, intimacy, physical activity, and access to medical care. Conversely, high anxiety symptoms do not automatically establish a disorder. Bereavement, realistic danger, discrimination, poverty, illness, relationship violence, or an unstable environment may produce understandable apprehension. Formulation must not turn a social or medical threat into a defect located only within the person.

Table 1. Distinguishing adaptive anxiety from a possible disorder

Question	More consistent with adaptive anxiety	More consistent with clinical concern
What is the context?	A recognizable challenge or danger.	Threat is absent, remote, overestimated, or the response persists after it has passed.
How flexible is the response?	Attention and arousal settle when information or safety changes.	The response remains rigid despite credible disconfirming information.
What happens to functioning?	Preparation improves performance or protection.	Avoidance, checking, reassurance, sleep loss, or concentration problems narrow life.
How long does it last?	Time-limited and linked to the situation.	Recurrent, pervasive, or prolonged beyond the expected adjustment period.
Can the person choose actions?	Anxiety is present but behavior remains values-consistent.	Behavior becomes organized primarily around immediate relief or threat prevention.
Is the danger realistic?	Appraisal broadly fits available evidence.	Probability or cost is persistently inflated, although insight may vary.
What else may explain it?	Ordinary stress response.	Consider an anxiety disorder, depression, a trauma-related disorder, OCD, substance or medication effects, a sleep disorder, or a medical condition.

IV. ANXIETY IS MULTICOMPONENT

No single component is sufficient to define anxiety. The conscious feeling may be dread, unease, tension, or a sense that something is wrong. Cognition may include threat predictions, images, self-focused attention, probability estimates, or attempts to solve uncertainty through repeated worry. Physiology can include palpitations, sweating, tremor, gastrointestinal discomfort, dizziness, breathlessness, muscular tension, or sleep disruption. Behavior may involve escape, avoidance, checking, reassurance seeking, overpreparation, freezing, or submission. Interpersonally, anxiety may be signaled through withdrawal, urgency,

irritability, repeated questions, or requests for protection. These elements influence one another but need not rise and fall together.

This distinction protects against reductionism. A racing heart is not anxiety by itself; exertion, infection, medications, arrhythmia, hyperthyroidism, hypoglycemia, and other conditions can produce it. An alarming thought is not a diagnosis; intrusive thoughts occur widely and may be interpreted differently. Avoidance can reflect anxiety, low mood, trauma, sensory overload, fatigue, pain, practical danger, or lack of interest. Clinical reasoning begins with the pattern and context rather than assigning one meaning to one sign.

A. *Conscious anxiety and defensive responding*

Neuroscience has sometimes been summarized as if an amygdala-based “fear circuit” creates the conscious feeling of fear or anxiety. LeDoux and Pine (2016) proposed a two-system framework that separates defensive survival circuits from cortical systems supporting conscious experience. The framework remains a model rather than a final map, but it makes a clinically useful point: bodily defense, avoidance, and the report “I feel anxious” are related processes, not interchangeable outputs of a single center. A patient may show pronounced physiological arousal without labeling it anxiety, or report intense anxious apprehension without dramatic autonomic signs.

Threat processing involves distributed networks and learning histories. Acute stress can alter cognitive control, attention, and habitual responding; chronic stress can affect sleep and regulation through multiple systems (McEwen, 2007). These findings should not become deterministic statements such as “your amygdala is overactive.” Group-level associations do not identify an individual patient's cause, and brain explanations do not diminish psychological, relational, or social explanations. These levels can be complementary.

B. *Interoception and bodily meaning*

Interoception is the sensing and interpretation of signals from within the body. Paulus and Stein (2006) proposed that altered prediction and appraisal of bodily states contribute to anxiety. In panic, a benign sensation may be read as evidence of imminent collapse; in health anxiety, ordinary variation may trigger checking and reassurance; in social anxiety, blushing or trembling may be treated as public proof of inadequacy. The sensation is real. The clinical question is how it is attended to, interpreted, and acted upon.

Trying to suppress bodily sensations can paradoxically increase monitoring. A person who repeatedly checks whether the heart has slowed must keep attention on the heart. Paced breathing may be useful when hyperventilation is present, but it can become a safety ritual if the person concludes that anxiety is dangerous unless breathing is controlled. Treatment

therefore distinguishes a flexible skill from a behavior that prevents corrective learning.

V. **THREAT, UNCERTAINTY, AND TIME**

Anxiety is often about a future that has not happened. Grupe and Nitschke (2013) organized research around uncertainty in anticipating possible threat: estimating probability and cost, learning about safety, regulating responses, and deciding how to act. Carleton (2016) argued that fear of the unknown may be a fundamental feature across anxiety presentations. These accounts help explain why the effects of reassurance are often short-lived. Reassurance can answer one proposition, but ordinary life cannot supply complete certainty about health, relationships, performance, or mortality.

Uncertainty is not necessarily the cause of anxiety. It is a condition under which existing beliefs, memories, vulnerabilities, and social realities become influential. Two people can face the same ambiguous email and construct different predictions. One sees routine delay; another sees rejection; a third remembers prior disciplinary action. Anxiety amplifies selected possibilities and may make them feel like facts. The person then acts on the felt certainty of a negative forecast while verbally insisting that nothing is certain.

Worry attempts to bridge this gap. It can be useful planning when it defines a problem, generates options, and ends in action. It becomes unproductive when it repeatedly asks hypothetical questions without new data, confuses thought with prevention, or substitutes mental rehearsal for tolerating uncertainty. The distinction is functional rather than based on topic: thinking about finances can be planning at 10 a.m. with bank statements and worry at 2 a.m. without the possibility of action.

Table 2. A functional analysis of anxious responding

Element	Questions for assessment
Trigger	What happened externally or internally just before anxiety rose? Include memories, images, sensations, messages, and absence of expected communication.
Prediction	What specific outcome seemed possible? What probability and cost did the person assign to it?
Attention	What was monitored, and what competing information was missed?
Meaning	What would the feared event say about safety, identity, responsibility, belonging, competence, or the future?
Action	What did the person do: approach, prepare, avoid, escape, check, seek reassurance, submit, freeze, or overcontrol?

Element	Questions for assessment
Immediate consequence	What relief, certainty, or protection followed?
Delayed consequence	What opportunities for learning, sleep, relationship quality, or autonomy were lost?
Context	Which medical, developmental, cultural, relational, occupational, and social factors shape the interpretation?

VI. ATTENTION, INTERPRETATION, AND MEMORY

Anxiety directs attention toward threat. Cisler and Koster (2010) distinguished rapid engagement, difficulty disengaging, and later avoidance of threat information. These patterns vary by task and disorder and should not be portrayed as universal biomarkers. Clinically, however, the person who scans a room for disapproval gathers a biased sample. Neutral or welcoming signals receive less processing, while a frown becomes highly memorable. The conclusion “people react badly to me” can then feel empirically supported even though the sampling procedure was selective.

Interpretation operates similarly. Ambiguous sensations, pauses, facial expressions, or messages are given threat-related meanings. A delayed reply can become abandonment; a headache can become serious disease; a momentary blank can become public humiliation. Cognitive work does not require replacing every negative thought with optimism. It asks whether the interpretation is a hypothesis, what evidence would discriminate among alternatives, and what action allows new information to emerge.

Memory is reconstructive. Anxiety can make threatening episodes and future simulations more accessible, while safety episodes may be dismissed as luck or successful prevention. If nothing bad follows extensive checking, the checking receives credit; if nothing bad happens without checking, the situation may be called unusually safe. Treatment addresses these rules of inference, not merely the surface thought.

VII. LEARNING, AVOIDANCE, AND SAFETY BEHAVIOR

Avoidance is one of the most powerful maintaining processes because it works immediately. Leaving a feared situation reduces arousal; canceling an appointment removes uncertainty; asking for reassurance briefly lowers doubt. Relief negatively reinforces the response, making it more likely next time. At the same time, avoidance prevents contact with information that could revise the threat prediction. The person learns “I escaped” rather than “I could cope” or “the predicted outcome did not occur.”

Safety behaviors are subtler. Examples include rehearsing every sentence, sitting near an exit, carrying rescue medication solely for reassurance when it is not clinically indicated, checking a partner's tone, monitoring the body, speaking quietly, or attending only with a companion. Some are reasonable precautions. They become clinically relevant when excessive, rigid, costly, or credited with preventing harm. Before reducing one, the therapist should clarify actual risk, consent, and the learning aim.

Exposure-based interventions create structured opportunities to approach feared cues while reducing avoidance or rituals enough for new learning. Contemporary accounts emphasize expectancy violation, variability, retrieval cues, and learning that can coexist with fear rather than requiring complete within-session habituation (Craske et al., 2014). Exposure is neither coercive nor unplanned; it is a collaborative, consent-based test of predictions in tolerable steps, followed by review of what was learned and how it generalizes.

Experiential avoidance broadens the analysis to attempts to control thoughts, memories, feelings, or sensations even when control efforts damage valued action (Hayes et al., 1996). Acceptance in this context does not mean approving danger or resigning oneself to suffering. It means making room for internal experience when the struggle to eliminate it has become the obstacle. The person can then choose behavior by purpose and evidence rather than by the demand for immediate emotional relief.

VIII. COMMUNICATION AND ANXIETY

Anxiety is also shaped and expressed through communication. Internally, sensations, memories, predictions, values, and action tendencies supply information that may conflict. Interpersonally, people signal danger, ask for reassurance, conceal vulnerability, negotiate protection, and interpret what is said or left unsaid. Haverkamp (2017a) described a communication-focused formulation in which uncertainty and misinterpretation can narrow the exchange of meaningful information. This perspective is a clinical framework developed by the author; it should be distinguished from evidence-based treatments such as disorder-specific CBT and used as a supplement rather than an unsupported replacement.

A communication-oriented assessment asks several concrete questions. Which message is difficult to send or receive? Which prediction is being treated as established fact? What information would change the prediction? Does repeated reassurance add information or merely regulate distress? Is silence interpreted as criticism, withdrawal as safety, or urgency as care? Which needs, values, or boundaries are not represented in the conversation? These questions transform a global state—“I am anxious”—into testable processes without

claiming that every anxiety symptom conceals a symbolic message.

Communication also affects treatment. Technical explanations can reduce shame, but excessive explanation can become reassurance. A clinician who speaks only about neurotransmitters may inadvertently erase the person's context; a clinician who speaks only about meaning may miss a medical cause or effective pharmacotherapy. Collaborative language identifies uncertainty honestly, explains the rationale for assessment and treatment, and makes room for disagreement. The patient's description remains data, not noise to be translated into the clinician's preferred theory.

IX. CLASSIFICATION AND DIFFERENTIAL DIAGNOSIS

Diagnostic categories provide common language, estimates of course, and links to studied treatments. They are most useful when applied with a careful differential diagnosis. Generalized anxiety disorder centers on excessive, difficult-to-control worry across domains with associated symptoms. Panic disorder concerns recurrent unexpected panic attacks and persistent concern or behavioral change. Agoraphobia involves fear and avoidance of situations in which escape or help may seem difficult. Social anxiety disorder concerns feared scrutiny and negative evaluation. Specific phobia is cued by a circumscribed object or situation. Separation anxiety can occur in adults as well as children (American Psychiatric Association, 2022; World Health Organization, 2022).

Several conditions can resemble or coexist with anxiety. Depression may involve agitation, dread, indecision, and withdrawal. Mania or hypomania may include reduced need for sleep, racing thoughts, irritability, and anxious activation; episodicity and mood elevation are diagnostically important. Trauma-related disorders involve responses to traumatic exposure, including intrusion, avoidance, negative changes in cognition or mood, and hyperarousal. OCD involves obsessions and compulsions rather than worry alone. Psychosis may involve fear arising from delusional beliefs or perceptual disturbances. ADHD and autism may involve attentional, sensory, executive, or social-communication difficulties that resemble or coexist with anxiety. Substance effects, including stimulant or cannabis intoxication and alcohol or sedative withdrawal, may cause or intensify symptoms.

Medical assessment is guided by presentation, not a universal battery. Thyroid disease, arrhythmia, asthma, anemia, infection, vestibular or other endocrine disorders, medication effects, sleep apnea, and other conditions may be relevant. New chest pain, syncope, focal neurological symptoms, severe breathlessness, delirium, or other acute warning signs warrant medical evaluation rather than a

presumption of panic. Rapid onset, pregnancy, older age, or polypharmacy should lower the threshold for investigation.

Urgent and safeguarding considerations

- Assess suicidal thoughts, self-harm, inability to care for basic needs, severe substance withdrawal, psychosis, and manic symptoms when indicated.
- Do not attribute new or severe physical symptoms to anxiety before considering urgent medical causes.
- Ask privately about coercive control, stalking, violence, exploitation, and realistic environmental danger.
- Review recent medication and substance changes, including dependence or withdrawal involving benzodiazepines, alcohol, and other sedatives.
- Use local emergency and safeguarding pathways when imminent risk is present; a review article cannot substitute for direct assessment.

X. DEVELOPMENT, COURSE, AND CONTEXT

Anxiety changes across development. Separation protest and fear of strangers can be expected at particular stages, while the same behavior may be unusual or impairing later. Adolescence brings expanding social evaluation, autonomy, bodily change, and decisions with uncertain consequences. Older adults may have different symptom language, medical burdens, losses, cognitive changes, and medication exposure. A diagnostic criterion can be written in age-neutral language while its meaning remains developmental. Assessment therefore asks not only whether a fear exists, but whether it fits the person's capacities, responsibilities, and environment at that developmental stage.

Many anxiety disorders begin before adulthood, although presentation to care may occur years later. Early onset and comorbidity are consistent epidemiological themes (Kessler et al., 2005; Bandelow & Michaelis, 2015). Longstanding avoidance may be mistaken for a fixed personality trait. Someone who has declined promotions, travel, invitations, or medical procedures for years may describe restriction as preference because alternatives are difficult to imagine. Treatment should respect genuine preference while expanding choice enough to explore whether anxiety constrains it.

Course is rarely a simple line from illness to cure. Symptoms wax and wane with stress, health, sleep, relationships, substance use, and opportunities for avoidance. A person may no longer meet full diagnostic criteria yet remain functionally restricted, or may report substantial symptoms while continuing valued activity. Remission, response, relapse, recurrence, and recovery should therefore be defined before interpreting outcome. Symptom reduction is important, but a reduction of 50% from an extreme baseline may still leave severe impairment. Conversely, residual physical arousal does not necessarily mean treatment failure if catastrophic meaning and avoidance have changed.

Temperament and learning create vulnerability without destiny. Behavioral inhibition, sensitivity to threat, early caregiving, modeling, adverse events, and chronic stress can

influence later anxiety, but associations at group level do not permit a retrospective causal story for every person (Craske et al., 2017). Therapists should be cautious about presenting a plausible childhood explanation as established fact. A formulation earns confidence when it predicts current patterns and helps guide change, not merely because it is narratively satisfying.

Culture influences what is feared, how distress is named, who is told, and which responses are available. Somatic descriptions may be the most acceptable or accurate language in one setting; spiritual, familial, moral, or occupational meanings may be central in another. Eye contact, assertiveness, privacy, dependence, and emotional expression do not carry identical meanings across communities. Cultural humility is not achieved by assigning a person to a checklist of group traits. It requires asking how the person and relevant community understand the experience, while still assessing impairment, safety, and treatable processes.

Social conditions can be causal and maintaining. Housing insecurity, racism, precarious employment, migration status, caregiving pressure, disability, poverty, war, and community violence create uncertainty that cannot be resolved through cognitive restructuring alone. An intervention may still help regulate arousal or expand coping, but it should not reinterpret an accurate threat as distortion. Advocacy, practical support, safeguarding, legal advice, or workplace accommodation may be the most relevant components of care. The distinction between realistic and excessive anxiety is sometimes clear only after the environment has been understood.

Relationships can protect against or maintain anxiety. Responsive support may facilitate approach, whereas criticism can intensify shame and concealment. Accommodation—performing rituals, speaking for the person, repeatedly reassuring, or reorganizing family life around avoidance—usually begins as care, but may strengthen the anxiety cycle and exhaust supporters. A collaborative plan validates distress, preserves needed assistance, and reduces responses that repeatedly function as threat prevention.

XI. VARIATION ACROSS ANXIETY PRESENTATIONS

The phrase “anxiety disorder” can obscure clinically decisive differences. In generalized anxiety, the mind shifts among possible harms and may treat worry as preparation or moral responsibility. In panic, bodily sensations and abrupt surges become feared. In social anxiety, scrutiny, visible anxiety, rejection, or causing offense may dominate. In specific phobia, the cue is more circumscribed. Agoraphobia concerns situations where escape or help seems difficult. Separation anxiety centers on harm to or loss of an attachment figure. Treatment principles overlap, but the feared prediction and the behavior preventing learning must be specified.

A. Generalized anxiety and worry

Generalized anxiety is not simply “having many worries.” Worry is excessive, difficult to control, spans domains, and is associated with symptoms and impairment over time (American Psychiatric Association, 2022). Patients may believe that worry prevents surprise, shows care, or keeps catastrophe in view. Simply telling someone to “stop worrying” ignores the strategy’s perceived function. A more useful inquiry separates current problems requiring decisions from hypothetical problems that invite endless certainty-seeking.

Treatment may include identifying worry triggers, testing beliefs about worry, solving actionable problems, approaching avoided uncertainty, and practicing flexible attention or relaxation. The aim is not indifference but a shift from repetitive simulation to proportionate preparation and disengagement. A scheduled worry period can show that postponement is possible, but it becomes a ritual if used to guarantee no worry at other times.

B. Panic and fear of sensations

A panic attack is a clinical event and a DSM-5-TR specifier; it does not itself establish panic disorder. Attacks occur across disorders, substance states, and medical conditions. Panic disorder requires recurrent unexpected attacks followed by persistent concern or maladaptive behavioral change. Feared outcomes include death, fainting, loss of control, “going crazy,” humiliation, or inability to escape. When medically appropriate, interoceptive exposure evokes selected sensations to test these predictions. It is not an endurance test; its target and safety rationale should be explicit.

Avoidance can spread through generalization. A first attack on a train may lead to avoiding trains, then crowds, then distance from home, then being alone. Each boundary makes immediate sense, yet the combined result can be severe restriction. Mapping the sequence reveals opportunities for graded return. Haverkamp (2017a) also emphasized that the self-directed interpretation—“this sensation means catastrophe”—can become more influential than the sensation itself.

C. Social anxiety

Social anxiety is more than shyness. The person expects scrutiny and fears negative evaluation, visible symptoms, rejection, or causing offense; situations are avoided or endured with intense distress. Self-focused attention and rehearsal reduce processing of the actual interaction. Safety behaviors—brief speech, limited eye contact, overpreparation, and post-event review—can reduce spontaneity and appear to confirm social inadequacy. Earlier JPPC work described restriction in relationships and work despite a wish for connection (Haverkamp, 2012).

Behavioral experiments test observable predictions: “If I pause, everyone will think I am incompetent,” or “If my hands shake, the other person will leave.” Flawless performance should not become the success criterion. The purpose is to gather broader evidence and learn that uncertainty and imperfection are tolerable and social missteps repairable. Where bullying, prejudice, or abusive power exists, treatment must address that reality rather than expose the person to preventable harm.

D. Specific phobia, agoraphobia, and separation anxiety

Specific fears can be highly impairing despite appearing narrow. Needle fear may prevent medical care; animal fear may restrict outdoor activity; fear of flying may separate family or limit work. Exposure is often central, but fainting-prone blood-injection-injury presentations may benefit from applied tension and medical precautions. Agoraphobic avoidance is organized around escape or access to help and may require attention to panic-related predictions and practical mobility. Separation anxiety in adults may be missed when repeated contact, reluctance to travel, nightmares, or avoidance is interpreted only as dependence.

Table 3. The feared outcome must guide treatment

Presentation	Examples of the central prediction	Common maintaining response
Generalized anxiety	“If I stop worrying, I will be unprepared or irresponsible.”	Repetitive hypothetical worry, checking, reassurance, overpreparation.
Panic disorder	“This sensation means I will die, faint, lose control, or be trapped.”	Body monitoring, escape, carrying safety objects, avoiding exertion.
Social anxiety disorder	“Visible anxiety or imperfection will lead to rejection or humiliation.”	Self-focused attention, rehearsal, concealment, brief speech, post-event rumination.
Specific phobia	“Contact with this cue will cause intolerable harm or loss of control.”	Cue avoidance, protective rituals, reliance on companions.
Agoraphobia	“Escape or help will be unavailable if symptoms occur.”	Staying near exits or home, route restriction, companion dependence.
Separation anxiety disorder	“Separation will cause harm, loss, or an inability to cope.”	Repeated contact, checking, refusal of travel or independent activity.

XII. ASSESSMENT AND FORMULATION

A comprehensive assessment begins with the person's own account: what anxiety feels like, when it began, what it predicts, and what it prevents. The time course helps distinguish a sudden medical or substance-related change from a longstanding pattern. Clinicians should ask about panic attacks, worry, social evaluation, phobic cues, trauma,

intrusive thoughts, compulsions, mood episodes, sleep, substances, physical health, medication, and family history. Developmental and cultural context affects both expression and meaning. Functional assessment should include work or study, caregiving, relationships, mobility, self-care, and activities the person no longer attempts.

Brief measures can support recognition and monitoring. The GAD-7 is a validated screening and severity measure for generalized anxiety symptoms (Spitzer et al., 2006), and disorder-specific instruments may better match panic, social anxiety, or phobic presentations. Scores are not diagnoses. They can be affected by medical illness, language, response style, and comorbidity. A baseline score becomes most useful when paired with a personally meaningful functional target, such as sleeping in one's bed, taking public transport, contributing in a meeting, or reducing reassurance calls.

Formulation organizes predisposing, precipitating, perpetuating, and protective factors. It should specify a modifiable cycle. “Low self-esteem causes anxiety” is too broad. “Before speaking, the person predicts visible shaking will lead to rejection, monitors the hands, grips the lectern, speaks briefly, and interprets the absence of criticism as evidence that gripping prevented humiliation” is testable. Formulations are hypotheses revised through observation and treatment, not verdicts about personality.

XIII. PRINCIPLES OF TREATMENT

Treatment depends on diagnosis, severity, impairment, prior care, preference, access, physical health, pregnancy, and risk. Psychoeducation and monitoring may suit mild or transient symptoms. Persistent disorders warrant disorder-specific psychological treatments, especially CBT with exposure when indicated (Carpenter et al., 2018; Hofmann et al., 2012). NICE recommends stepped care for generalized anxiety and panic disorder, including low-intensity interventions, high-intensity CBT, applied relaxation for GAD, and medication according to presentation and severity (National Institute for Health and Care Excellence, 2020).

Medication can be appropriate, but “anxiety medication” is not one undifferentiated category. SSRIs and SNRIs have evidence across several anxiety disorders; selection depends on the particular disorder, prior response, adverse effects, interactions, overdose risk, withdrawal, and preference. Benefits develop over time, and early activation may occur. Benzodiazepines can reduce acute anxiety but carry risks of sedation, falls, impaired driving, tolerance, dependence, and withdrawal; guidelines generally restrict their routine long-term role. Medication decisions require individual prescribing assessment and should not be inferred from a conceptual review.

Psychotherapy should target the processes that maintain the patient's presentation. Exposure addresses avoidance and feared predictions. Cognitive methods examine interpretations and probability or cost estimates. Behavioral experiments generate information. Applied relaxation may be used for generalized anxiety. Metacognitive or acceptance-based methods may help when the relationship to worry and internal experience is central. Relationship or family work may be relevant when accommodation, reassurance, or conflict maintains symptoms. Sleep, caffeine, alcohol, exercise, pain, and chronic stress deserve attention, but lifestyle advice should not imply that severe anxiety is caused by insufficient discipline.

Haverkamp (2012, 2017b) argued for combining symptom-focused treatment with attention to the person's life, communication, and choices. In practice, this means offering indicated evidence-based treatment while also assessing meaning, relationships, and vocational consequences. Shared decision-making should make the rationale, alternatives, uncertainties, and review point explicit.

Table 4. Matching a maintaining process to a clinical response

Maintaining process	Possible response and learning aim
Avoidance of feared situations	Collaborative graded exposure; learn what occurs and whether coping is possible without habitual escape.
Catastrophic interpretation of sensations	Medical review when indicated, interoceptive exposure, and testing of alternative explanations.
Reassurance and checking	Agree on measured reduction, tolerate uncertainty, and track whether feared outcomes occur without the ritual.
Threat-focused attention	Practice flexible external attention and gather a less selective sample of social or environmental information.
Unproductive worry	Separate solvable problems from hypothetical worry; schedule problem-solving and practice disengagement or acceptance.
Relationship accommodation	With consent, help supporters validate distress without repeatedly performing the anxiety-driven response.
Poor treatment fit or limited engagement	Revisit diagnosis, rationale, accessibility, adverse effects, cultural fit, alliance, and practical barriers before declaring resistance.
Realistic threat	Safety planning, advocacy, medical care, legal or social support; do not use exposure to normalize preventable danger.

XIV. CLINICAL COMMUNICATION IN PRACTICE

How anxiety is explained can itself alter care. "Nothing is wrong" may be intended as reassurance but can invalidate severe symptoms and provide no model for action. "Your brain is misfiring" may reduce blame yet imply permanence and ignore context. "Your anxiety is trying to tell you something" may invite reflection but overstate intentionality. A balanced explanation is that the person has a real alarm response, that several systems and learned predictions contribute, that the alarm may be overgeneralized or maintained by understandable coping, and that assessment and practice can change the pattern.

Questions should be concrete and non-leading. "What did you think would happen next?" is usually more informative than "Why are you anxious?" "What did you do to feel safer?" reveals maintaining behavior without accusation. "What did that response cost later?" connects short-term relief with long-term restriction. "What evidence would make the situation safer or more dangerous?" respects uncertainty. "Which action would matter even if anxiety came along?" begins to restore choice.

When family or partners participate, the clinician distinguishes validation from accommodation. Validation communicates that distress is real and understandable. Accommodation follows the anxiety-driven rule—for example, by checking repeatedly, answering the same reassurance question, or taking over all feared tasks. Support can instead acknowledge distress, remind the person of an agreed plan, reinforce approach, and preserve warmth after limits are set. Changes should be gradual and collaborative; abrupt withdrawal of support can feel punitive and may be unsafe.

Documentation should preserve uncertainty. After one episode, record symptoms as consistent with a panic attack and note that medical causes and panic-disorder criteria require assessment, rather than writing that the patient "has panic disorder." Notes can capture the prediction, task, safety behaviors, learning, adverse effects, and functional outcome, supporting supervision and reassessment.

XV. FROM FORMULATION TO AN INDIVIDUAL CARE PLAN

A formulation is useful only if it changes a decision. The clinician can summarize anxiety in a short sequence: relevant vulnerabilities and context; current trigger; specific prediction; bodily, attentional, and emotional response; avoidance or safety behavior; immediate consequence; delayed consequence; and the valued activity that has been restricted. The patient should recognize the account and be able to correct it. A formulation written only in technical language

may be accurate on paper yet unusable during an anxious episode.

Treatment sequencing should also reflect capacity. Severe sleep loss, intoxication or withdrawal, acute medical symptoms, suicidal risk, psychosis, or mania may require stabilization before routine outpatient exposure-based work. This is not a rule that all distress must disappear before psychological work. It is a risk judgment about whether the patient can understand, consent to, and learn from the intervention. Once acute risk is addressed, prolonged postponement can itself strengthen avoidance.

Progress should be reviewed with more than a symptom score. Behavior shows whether the patient is re-entering previously avoided life: traveling independently, speaking in a meeting, or sleeping without repeated checking can be meaningful recovery even while anxiety remains. Conversely, sedation may lower a score while function and choice stay narrow. The patient and clinician should agree which trade-offs are acceptable, record early signs of renewed avoidance, and specify when to repeat a practiced response or seek review.

The plan includes a stop or revision rule. If a behavioral experiment repeatedly produces the feared event, the prediction may be realistic or the experiment poorly designed. If medication causes significant harm without meaningful benefit, persistence is not automatically therapeutic. If a formulation fails to predict when anxiety rises and falls, it should be changed. Clinical confidence should remain accountable to observation.

Table 5. Linking formulation to treatment

Dominant finding	Initial target	Example outcome	Reason to revise
Fear of bodily catastrophe	Medical differential and interoceptive or situational exposure	Less checking and resumed activity despite sensations	New atypical symptoms or evidence of medical risk
Hypothetical worry and reassurance	Problem classification and uncertainty practice	Less repeated questioning and more completed action	Concern yields actionable new information
Social evaluation and safety behavior	Attention shift, behavioral experiment, graded participation	More genuine speech and less rehearsal or concealment	Actual hostility, discrimination, or unsafe context
Panic-related escape	Collaborative exposure with reduced rescue behavior	Wider travel and less exit dependence	Task exceeds medical safety or consent boundaries

Dominant finding	Initial target	Example outcome	Reason to revise
Broad threat after sleep or substance disruption	Sleep and substance assessment coordinated with anxiety care	Improved regulation and treatment engagement	Mood switch, withdrawal risk, or another sleep disorder
Relationship accommodation	Agreed supportive response and graded transfer of action	Preserved warmth with greater autonomy	Coercion, violence, disability, or legitimate care need
Realistic external danger	Protection, resources, planning, and advocacy	Safer conditions and proportionate vigilance	The threat or available protections change

XVI. LIMITATIONS AND OPEN QUESTIONS

Anxiety research is heterogeneous. Diagnostic categories group people with different histories and maintaining mechanisms; average effects do not determine individual response. Laboratory threat tasks simplify relationships and chronic adversity. Neuroimaging findings are vulnerable to reverse inference and do not yield a routine test for “anxiety circuits.” Many psychotherapy trials exclude complex comorbidity, and wait-list controls may overstate effects relative to active comparators. Cultural concepts of distress and structural threats remain underrepresented.

The communication-oriented synthesis offered here is also limited. Communication is so broad that it can become unfalsifiable unless translated into observable exchanges, predictions, and outcomes. It must not be used to blame patients for illness, to imply that all symptoms carry one discoverable message, or to substitute theory for treatment evidence. Its value lies in generating collaborative questions about information, meaning, expression, and choice while remaining accountable to clinical outcomes.

XVII. CONCLUSION

Anxiety is adaptive, but becomes clinically significant when it is persistent, disproportionate, inflexible, distressing, or impairing. Because it involves physiology, attention, interpretation, behavior, and communication, assessment should identify the syndrome, context, maintaining processes, comorbidity, medical contributors, realistic danger, and risk. Treatment should combine diagnosis-specific evidence with shared decisions and the patient’s relational and practical aims. The goal is proportionate alarm and greater freedom of action, not the elimination of all anxiety.

Haverkamp, C. J. (2022). What Is Anxiety? A Clinical and Communication-Oriented Review. *J Psychiatry Psychotherapy Communication*, 2022 Dec 31;11(4):91-100

XVIII. DISCLOSURES

Conflicts of interest—The author developed Communication-Focused Therapy® and has related publications. The framework is identified as an author-developed clinical model in this review and is not presented as a replacement for established evidence-based treatment. No other conflicts were reported.

Funding—No specific funding was reported for this article.

Author contributions—Christian Jonathan Haverkamp is the sole named author and is responsible for the conception, literature review, manuscript preparation, and approval of the final version.

Patient material—No identifiable patient material is presented.

XIX. REFERENCES

- American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). American Psychiatric Association Publishing. <https://doi.org/10.1176/appi.books.9780890425787>
- Bandelow, B., & Michaelis, S. (2015). Epidemiology of anxiety disorders in the 21st century. *Dialogues in Clinical Neuroscience*, 17(3), 327–335. <https://doi.org/10.31887/DCNS.2015.17.3/bbandelow>
- Carleton, R. N. (2016). Fear of the unknown: One fear to rule them all? *Journal of Anxiety Disorders*, 41, 5–21. <https://doi.org/10.1016/j.janxdis.2016.03.011>
- Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A. J., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, 35(6), 502–514. <https://doi.org/10.1002/da.22728>
- Cisler, J. M., & Koster, E. H. W. (2010). Mechanisms of attentional biases towards threat in anxiety disorders: An integrative review. *Clinical Psychology Review*, 30(2), 203–216. <https://doi.org/10.1016/j.cpr.2009.11.003>
- Craske, M. G., Stein, M. B., Eley, T. C., Milad, M. R., Holmes, A., Rapee, R. M., & Wittchen, H.-U. (2017). Anxiety disorders. *Nature Reviews Disease Primers*, 3, 17024. <https://doi.org/10.1038/nrdp.2017.24>
- Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy*, 58, 10–23. <https://doi.org/10.1016/j.brat.2014.04.006>
- Grupe, D. W., & Nitschke, J. B. (2013). Uncertainty and anticipation in anxiety: An integrated neurobiological and psychological perspective. *Nature Reviews Neuroscience*, 14(7), 488–501. <https://doi.org/10.1038/nrn3524>
- Haverkamp, C. J. (2012). A case of severe anxiety. *J Psychiatry Psychotherapy Communication*, 1(2), 35–40.
- Haverkamp, C. J. (2017a). Communication-Focused Therapy (CFT) for anxiety and panic attacks. *J Psychiatry Psychotherapy Communication*, 6(4), 91–95.
- Haverkamp, C. J. (2017b). Treatment-resistant anxiety. *J Psychiatry Psychotherapy Communication*, 6(3), 61–67.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experimental avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64(6), 1152–1168. <https://doi.org/10.1037/0022-006X.64.6.1152>
- Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, 36(5), 427–440. <https://doi.org/10.1007/s10608-012-9476-1>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602. <https://doi.org/10.1001/archpsyc.62.6.593>
- LeDoux, J. E., & Pine, D. S. (2016). Using neuroscience to help understand fear and anxiety: A two-system framework. *American Journal of Psychiatry*, 173(11), 1083–1093. <https://doi.org/10.1176/appi.ajp.2016.16030353>
- McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiological Reviews*, 87(3), 873–904. <https://doi.org/10.1152/physrev.00041.2006>
- National Institute for Health and Care Excellence. (2020). Generalised anxiety disorder and panic disorder in adults: Management (Clinical guideline CG113; updated 15 June 2020). <https://www.nice.org.uk/guidance/cg113>
- Paulus, M. P., & Stein, M. B. (2006). An insular view of anxiety. *Biological Psychiatry*, 60(4), 383–387. <https://doi.org/10.1016/j.biopsych.2006.03.042>
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. <https://doi.org/10.1001/archinte.166.10.1092>
- World Health Organization. (2022). ICD-11 for mortality and morbidity statistics (Version 02/2022). <https://icd.who.int/browse11/l-m/en>