



Anxiety from the Perspective of Scientific Psychology: Diagnosis, Etiology and Clinical Interventions

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Summary

Anxiety is a multifactorial psychological condition that affects millions of individuals across different age groups and sociocultural contexts. This article aims to analyze, from the perspective of psychological science, the diagnostic, etiological, and therapeutic aspects of anxiety disorders, excluding non-empirical approaches. The theoretical foundations of anxiety, the contributions of Cognitive Behavioral Therapy (CBT), psychodynamics, and developmental psychology, as well as empirical evidence of clinical efficacy, are discussed. The text also addresses the comorbidity of anxiety with other mental disorders, the somatic manifestations of anxiety, and the importance of evidence-based psychological work. The article aims to contribute to the theoretical and practical training of mental health professionals, enhancing the technical and scientific understanding of anxiety and its clinical implications.

Keywords: Clinical psychology; Anxiety; Cognitive-Behavioral Therapy; Psychopathology; Psychological interventions.

Abstract

Anxiety is a multifactorial psychological condition that affects millions of individuals across age groups and sociocultural contexts. This article aims to analyze, through the lens of scientific psychology, the diagnostic, etiological, and therapeutic aspects of anxiety disorders, excluding non-empirical approaches. It discusses the theoretical foundations of anxiety, contributions from Cognitive Behavioral Therapy (CBT), psychodynamic psychology, and developmental psychology, as well as empirical evidence of clinical efficacy. The text also addresses comorbidities with other mental disorders, somatic manifestations of anxiety, and the importance of evidence-based psychological practice. The article seeks to contribute to the theoretical and practical training of mental health professionals, evaluating a technical and scientific understanding of anxiety and its clinical implications.

Keywords: Clinical psychology; Anxiety; Cognitive Behavioral Therapy; Psychopathology; Psychological interventions.



1. Conceptualization and Clinical Classifications of Anxiety

In scientific psychology, anxiety is defined as an emotional state characterized by the anticipation of danger or threat, accompanied by physical, cognitive, and behavioral symptoms. From an evolutionary perspective, it represents an adaptive mechanism whose function is to prepare the body to react to potentially dangerous situations. However, when excessive, disproportionate, or persistent, anxiety ceases to be protective and becomes a dysfunctional clinical condition. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), anxiety disorders include several specific manifestations, such as generalized anxiety disorder (GAD), specific phobias, panic disorder, agoraphobia, among others (American Psychiatric Association, 2013).

The distinction between normal and pathological anxiety is based on the intensity, duration, and functional impact of symptoms. While common anxiety is transient and proportional to the triggering stimulus, anxiety disorders are characterized by intense distress, social or occupational impairment, and a maladaptive response to stimuli that do not warrant such a reaction. According to Barlow (2002), pathological anxiety arises when there is hyperactivity of the vigilance and alarm systems, resulting in catastrophic anticipations and disorganized responses. This conceptualization broadens clinical understanding and allows for more precise and informed interventions.

In the field of psychopathology, anxiety disorders are the most prevalent mental disorders, affecting between 10% and 30% of the global population at some point in their lives, with variations depending on gender, age, and cultural context (Kessler et al., 2005). Generalized anxiety disorder (GAD), for example, presents with excessive and persistent worries that are difficult to control, often accompanied by physical symptoms such as muscle tension, fatigue, and insomnia. Panic disorder, on the other hand, is characterized by sudden episodes of intense fear associated with autonomic symptoms such as tachycardia, sweating, and a feeling of impending doom. These conditions, if not treated appropriately, can progress to significant mental health problems.

Current nosological classifications, such as the DSM-5 and the International Classification of Diseases (ICD-10 and ICD-11), seek to categorize anxiety disorders systematically, using objective diagnostic criteria based on clinical evidence. These classifications contribute to the standardization of diagnosis and enable the development of more effective therapeutic protocols. However, criticisms are leveled at the overly descriptive nature of these manuals, which often neglect the psychodynamic and subjective aspects of the anxiety experience (Millon, 1991). Despite this, their clinical and scientific importance is undeniable, and they are widely used in psychological and psychiatric practice.

It is essential to consider that anxiety manifests differently among individuals and at different stages of life. In children, for example, it can appear as separation anxiety or school phobia, while in the elderly it is often confused with somatic symptoms or cognitive decline (Beesdo, Knappe, & Pine, 2009). This variability requires careful clinical listening from the psychologist, considering the developmental context and environmental factors involved. Understanding individual specificities is essential for diagnosis.



differential, avoiding overdiagnoses and favoring more ethical and personalized interventions.

Finally, understanding anxiety from a clinical perspective requires recognizing its structural complexity. It is not merely an isolated symptom, but a phenomenon that encompasses neurobiological, cognitive, affective, and social dimensions. Accurate conceptualization and classification are the first step toward effective, scientifically based therapeutic interventions. Psychology, as a science and professional practice, must remain up-to-date on the empirical evidence and theories that support the understanding of anxiety disorders, always in dialogue with the diversity of clinical manifestations observed in clinics, public services, and mental health institutions.

2. Etiology and Risk Factors in Anxiety Disorders

The etiology of anxiety disorders is understood as multifactorial, involving complex interactions between genetic predispositions, neurobiological alterations, psychosocial events, and learning patterns. Several studies indicate a significant hereditary basis for anxiety disorders, with heritability rates ranging from 30% to 50%, especially in cases of panic disorder and social phobia (Hettema, Neale, & Kendler, 2001). Genetics, however, is not deterministic; it establishes vulnerabilities that may or may not manifest depending on the interaction with environmental factors. The biopsychosocial model proves the most effective in explaining the origin of these disorders, as it integrates biological, psychological, and social components into a coherent and clinically applicable framework.

Neurobiological changes are also observed in individuals with anxiety disorders. Functional neuroimaging studies indicate hyperactivity in the amygdala, a brain structure responsible for threat processing, and dysfunction in the prefrontal cortex, an area linked to inhibitory control and emotional regulation (Etkin and Wager, 2007). Furthermore, neurotransmitter systems such as GABA, serotonin, and norepinephrine play an essential role in emotional balance and, when altered, contribute to the manifestation of anxiety symptoms. These neuroscientific data not only reinforce the organic basis of anxiety but also support the use of combined approaches, such as psychotherapy and psychopharmacology, when necessary.

The family and social environment plays a crucial role in the development of anxiety disorders. Experiences of neglect, physical or emotional abuse, and overprotective parenting styles are associated with increased vulnerability to anxiety (Manfro et al., 2003). Children exposed to chaotic environments or anxious parental figures internalize dysfunctional coping patterns, which later manifest as avoidance strategies or hypervigilance. Bowlby's (1969) attachment theory also provides important contributions, suggesting that insecure attachments in childhood are associated with difficulties in emotion regulation and a propensity for chronic anxiety states.

Individual risk factors include temperamental characteristics such as behavioral inhibition, neuroticism, and low frustration tolerance. These traits may predispose



individuals to more intense responses to stressful situations, especially in social or performance contexts. Neuroticism, for example, has been widely associated with the tendency to experience negative emotions more frequently and intensely (Clark & Watson, 1991). These temperamental aspects, when not modulated throughout development, favor the internalization of distorted cognitive patterns, which reinforce anxiety and hinder adaptation to the environment.

Traumatic and stressful events throughout life are also recognized as precipitating factors for anxiety disorders. Significant losses, sudden changes, chronic illnesses, and situations of violence contribute to the dysregulation of stress systems, especially in already vulnerable individuals. Post-traumatic stress disorder (PTSD), for example, is directly linked to exposure to traumatic experiences and highlights how the psyche can react in a disorganized manner to the disruption of fundamental expectations of safety and predictability (Yehuda et al., 2015). Therefore, the individual's life history and current context must be carefully considered in the clinical assessment.

Given the etiological complexity of anxiety disorders, it is crucial that psychology professionals adopt an investigative and integrative approach that goes beyond observing immediate symptoms. A thorough understanding of risk factors allows for the formulation of more accurate clinical hypotheses and the selection of interventions compatible with the patient's history and psychological functioning. By recognizing the multiplicity of possible causes, psychologists avoid reductionism and enrich their practice with a broader, more ethical approach that is sensitive to the uniqueness of each case.

3. Cognitive-Behavioral Approaches to Treating Anxiety

Cognitive Behavioral Therapy (CBT) is considered one of the most effective psychotherapeutic approaches for treating anxiety disorders, with a broad empirical base validated in clinical studies and meta-analyses. Based on the work of Aaron Beck, CBT assumes that dysfunctional thoughts contribute to the maintenance of anxiety, as they shape the individual's interpretation of themselves, the world, and the future (Beck, 2013). In clinical practice, cognitive restructuring is a central tool, allowing patients to identify and reformulate distorted automatic thoughts, such as catastrophizing, generalizations, and arbitrary inferences.

In the context of anxiety disorders, CBT operates from an individualized conceptualization, in which negative cognitive schemas and core beliefs are investigated and progressively modified. For example, individuals with social anxiety disorder often hold beliefs such as "I am inadequate" or "I will be ridiculed," which guide avoidance behaviors and fuel the anxiety cycle (Clark & Wells, 1995). Through behavioral experiments and Socratic questioning, CBT promotes the confrontation of these beliefs and encourages gradual exposure to feared situations, strengthening self-confidence and tolerance for discomfort.

Systematic exposure is an essential component of CBT applied to anxiety. It involves the planned and progressive confrontation with feared stimuli, with the goal of promoting



habituation and reduce avoidance, one of the main drivers of anxiety. Clinical studies show that exposure, when properly managed, can generate lasting emotional restructuring, even in severe cases such as obsessive-compulsive disorder (Craske et al., 2008). The hierarchy of exposures and monitoring of anxiety levels during the process allow the patient to develop greater control and autonomy over their emotional responses.

Another important feature of CBT is coping skills training, which aims to expand the individual's behavioral repertoire in anxiety-provoking situations. Techniques such as problem-solving, assertiveness, progressive muscle relaxation, and diaphragmatic breathing are used to reduce levels of physiological activation and strengthen feelings of self-efficacy. Although the focus of this article does not include meditative or contemplative-based techniques, it is important to emphasize that there are a variety of scientifically validated non-pharmacological strategies within CBT (Barlow, 2002). The combined use of these strategies has proven effective in reducing relapses and increasing treatment adherence.

CBT also offers useful tools for relapse prevention, a crucial step in the clinical management of anxiety disorders. Early identification of triggers, creation of action plans for moments of crisis, and consolidation of new cognitive schemas favor the maintenance of therapeutic gains in the long term. Structured programs lasting between 12 and 20 sessions generally produce significant results, but continued clinical monitoring may be indicated in cases with comorbidities or a history of frequent relapses (Hofmann et al., 2012). CBT's adaptability to different cultural contexts and age groups also contributes to its widespread acceptance in the mental health field.

Finally, it is important to emphasize that, despite its technical and structured orientation, CBT is not limited to the mechanical application of techniques. The quality of the therapeutic relationship, empathy, and the psychologist's ability to adapt treatment to the patient's needs are fundamental factors for clinical success. The cognitive-behavioral approach, therefore, represents a combination of methodological rigor and clinical sensitivity, being one of the most recommended for the treatment of anxiety, according to international guidelines and established empirical evidence (National Institute for Health and Care Excellence – NICE, 2011).

4. Psychodynamic Perspectives on Anxiety

Psychodynamic approaches offer a deeper understanding of anxiety by considering its origins in unconscious conflicts, defense mechanisms, and internalized object relations. Freud, in his classic work *Inhibition, Symptom, and Anxiety* (1926), conceptualized anxiety as a psychic alarm signal in the face of internal threats, arising from the clash between the id, ego, and superego. From this structural view of the mind, anxiety is not simply a response to external stimuli, but a symbolic manifestation of repressed psychic conflicts, often related to sexuality, aggression, or the fear of losing significant affective objects.



The evolution of psychoanalytic theory has broadened the understanding of anxiety, particularly through contributions from object relations theory. Melanie Klein, for example, conceptualized persecutory anxiety and depressive anxiety as fundamental emotional experiences in the early stages of development, derived from unconscious fantasies related to internalized parental figures. These forms of anxiety are organized around the paranoid-schizoid and depressive positions, which shape the individual's emotional structure (Klein, 1946). The internalization of threatening objects, according to this interpretation, can generate chronic states of vigilance and distress, often observed in anxiety disorders.

Contemporary psychodynamic authors, such as Otto Kernberg and Nancy McWilliams, emphasize that anxiety may be related to the fragility of personality structure and the difficulty in integrating affects and impulses. In individuals with borderline personality disorder, for example, anxiety appears as a manifestation of diffuse anguish, resulting from identity instability and ruptures in interpersonal bonds (Kernberg, 2004).

McWilliams (1999) emphasizes that recognizing the nature of anxiety allows the clinician to understand the type of psychological suffering involved and choose interventions consistent with the level of personality organization.

Psychodynamic interventions therefore seek not only to alleviate symptoms of anxiety but also to elaborate on its unconscious meanings. Through the interpretation of latent content, analysis of transference, and exploration of defenses, the patient gradually becomes conscious of the conflicts that give rise to their anxiety. This approach allows for a deeper and more lasting transformation of the psychic structure, promoting not only symptom control but also emotional maturation and expanded capacity for insight. Clinical studies, such as those by Leichsenring et al. (2009), have demonstrated the efficacy of psychodynamic psychotherapy in treating anxiety, particularly in cases resistant to more directive interventions.

Furthermore, psychodynamically oriented psychotherapies offer flexibility in treatment delivery, adapting them to the severity of the condition and the patient's mentalization capacity. In their brief or focused form, these approaches maintain the fundamental principles of internal conflict analysis, but with greater structure and goal definition, making them especially useful in contemporary clinical settings. The therapist acts as a facilitator of self-knowledge, helping the patient find new ways to cope with distress without resorting to rigid defenses or repetitive patterns of functioning that perpetuate suffering.

The psychodynamic perspective, by prioritizing listening to the individual's uniqueness and history, makes a valuable contribution to the clinical understanding of anxiety. Although it doesn't offer protocols as systematized as CBT, it offers a profound and respectful approach to subjectivity, focusing on psychic transformation rather than simply suppressing symptoms. Thus, psychodynamic psychotherapy remains a robust and scientifically supported alternative for treating anxiety, being especially recommended for chronic cases with complex emotional comorbidities or resistance to more structured treatments.



5. Anxiety and Comorbidities: Diagnostic and Therapeutic Interfaces.

Anxiety rarely presents as an isolated condition. Clinical and epidemiological studies indicate a high prevalence of comorbidity between anxiety disorders and other mental disorders, such as depression, personality disorders, and substance use disorders. This association compromises both diagnosis and therapeutic management, requiring psychologists to carefully listen to the patient's condition and consider the multiple dimensions of psychological distress. Identifying comorbidities is essential for formulating more comprehensive clinical hypotheses and tailoring interventions to the patient's specific situation (Kessler et al., 2005).

Depression is by far the most common comorbidity among patients with anxiety disorders. It is estimated that approximately 60% of individuals with generalized anxiety disorder also experience depressive episodes throughout their lives (Lamers et al., 2011). The symptomatic overlap between anxiety and depression—such as insomnia, fatigue, and difficulty concentrating—can complicate differential diagnosis and lead to the selection of inappropriate therapeutic approaches. Therefore, it is essential to carefully assess the predominant symptoms, clinical course, and the patient's life context before defining a treatment plan.

Another relevant association occurs with personality disorders, especially avoidant, dependent, and obsessive-compulsive personality disorders, which are part of Cluster C. In these cases, anxiety does not present as an episodic state, but as a structural personality trait, present in interpersonal relationships, self-concept, and coping with adversity. The identification of rigid relational patterns, low self-esteem, and a strong need for social approval indicates the presence of structural aspects that require longer psychotherapeutic interventions aimed at reorganizing internal bonds (Millon, 1991).

In the context of legal substances, the relationship between anxiety and the abuse of alcohol and anti-anxiety medications, especially benzodiazepines, stands out. In many cases, these medications are used to alleviate immediate symptoms of tension, phobia, or insomnia. However, prolonged use without proper professional supervision can result in chemical dependency, drug tolerance, and worsening of anxiety. It is the psychologist's responsibility to identify patterns of problematic use and, when necessary, refer the patient for medical evaluation, always maintaining clinical practice within the legal and ethical boundaries of the profession.

The coexistence of anxiety disorders with other clinical conditions requires careful and often multidisciplinary treatment planning. Working collaboratively with psychiatrists, primary care physicians, and social workers can be crucial to ensuring treatment effectiveness. In the field of psychology, Cognitive Behavioral Therapy offers techniques adapted to treat anxiety with depressive symptoms or a history of substance use, such as restructuring dysfunctional beliefs and training in healthier coping strategies (Hofmann et al., 2012).



Finally, understanding anxiety within a comorbid context broadens the psychologist's ability to intervene in an integrated, technical, and ethical manner. Recognizing the multiple factors that contribute to a patient's suffering is essential for developing a realistic and effective therapeutic plan. By valuing the uniqueness of individuals and their contexts, psychological science establishes itself as an indispensable tool in addressing anxiety disorders and their more complex clinical interfaces.

6. Evidence-Based Psychological Interventions and Final Considerations

Psychological interventions aimed at treating anxiety must be based on solid empirical evidence, especially in a clinical setting characterized by diagnostic complexity and a variety of symptomatic manifestations. The psychologist's work should be guided by validated theoretical models and therapeutic strategies with proven efficacy in controlled clinical studies. Among these approaches, Cognitive Behavioral Therapy (CBT) continues to be considered the gold standard for treating various anxiety disorders, according to national and international guidelines (Barlow, 2002; Hofmann et al., 2012). CBT allows for structured and focused interventions, with defined therapeutic goals and practical strategies for cognitive restructuring and behavioral reduction of anxiety.

In addition to CBT, psychodynamic psychotherapy has proven effective, especially in cases where anxiety symptoms are associated with unconscious conflicts, dysfunctional attachment patterns, or personality traits. This approach, although less structured than CBT, promotes profound transformations by enabling symbolic access to the roots of psychological suffering, strengthening the patient's mentalization capacity and affective repertoire (Leichsenring et al., 2009). The choice of therapeutic model should consider the patient's profile, the severity of the condition, available internal resources, and the sociocultural context in which they are inserted, respecting the ethical and legal principles of psychological practice in Brazil.

Complementary interventions, such as social skills training, psychoeducation, and the use of thought records, have been incorporated into clinical practices due to their effectiveness in managing anxiety symptoms. These strategies help patients recognize dysfunctional behavior patterns, develop greater frustration tolerance, and develop more adaptive coping strategies. When applied systematically, these resources contribute not only to symptom remission but also to preventing relapses and promoting autonomy in coping with anxiety-provoking situations in everyday life (Clark and Beck, 2010).

Psychologists' work with anxiety also requires constant theoretical and technical updating. Scientific research in the field of psychopathology has evolved, allowing the identification of new variables involved in the development and maintenance of anxiety disorders. Studies using neuroimaging, behavioral genetics, and psychometrics offer support for improving clinical practices and personalizing treatments. Psychologists who are grounded in science strengthen their clinical authority, ethical responsibility, and commitment to patient well-being, respecting the guidelines established by professional boards and academic institutions.



The conclusion drawn from the theoretical review presented is that anxiety, as a complex psychological phenomenon, must be approached with technical depth, scientific responsibility, and clinical sensitivity. Understanding the etiological mechanisms, associated comorbidities, and the most appropriate intervention strategies is essential for developing effective psychological practice. Authors such as Barlow (2002), Clark and Watson (1991), and Millon (1991) contribute significantly to this panorama by emphasizing the need for integrative and scientifically based approaches, without sacrificing the individual's unique and ethical perspective.

It can be concluded, therefore, that clinically addressing anxiety requires a balance between methodological rigor and openness to subjectivity. Psychology, as an applied science, has robust theoretical models and effective interventions to address anxiety in its various manifestations. It is up to professionals to make responsible use of these resources, respecting the legal limits of psychological practice and maintaining ongoing training. A commitment to mental health cannot be separated from a commitment to science. Thus, psychology reaffirms its social, ethical, and clinical relevance in addressing anxiety, offering legitimate, proven, and humane paths to rebuilding mental well-being.

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