Medications for anxiety

GAD, panic, and social anxiety at a glance. First-line, augmentation, and where benzodiazepines fit and where they do not. Reviewed against current guidelines as of June 8, 2026.

SSRIs and SNRIs are first-line for generalized anxiety, panic, social anxiety, and most other anxiety disorders. They work about as well as benzodiazepines without the dependence risk. Benzodiazepines still have a role, mainly as a bridge and for PRN use. Companion to the full guide at psychiatryrx.org/guides/medications-for-anxiety/.

First-line options

Drug	Class	Notes
Sertraline	SSRI	Broad anxiety approvals: GAD, panic, PTSD, social anxiety, OCD. Often the default.
Escitalopram	SSRI	FDA-approved for GAD. Simple dosing, tolerable. Less anxiety-specific data than sertraline.
Paroxetine	SSRI	Broad anxiety approvals. Sedating, most weight gain, worst discontinuation. Not first pick anymore.
Fluoxetine	SSRI	Approved for panic and OCD. Long half-life is forgiving. Activating early.
Fluvoxamine	SSRI	OCD approval, off-label in other anxiety. Strong CYP1A2 inhibitor.
Venlafaxine XR	SNRI	Approved for GAD, panic, and social anxiety. Watch BP at higher doses.
Duloxetine	SNRI	Approved for GAD. Best pick when anxiety comes with chronic pain.
Buspirone	5-HT1A partial agonist	GAD only. No dependence, no sedation. Slow onset (2 to 4 weeks). Does nothing for panic.

Second-line and augmentation

Drug	Class	When to consider
Alprazolam, clonazepam, lorazepam, diazepam	Benzodiazepine	Bridge while an SSRI titrates in, PRN for anticipated high-anxiety, or chronic use when alternatives have failed. Lowest dose, shortest duration that works.
Mirtazapine	Atypical antidepressant	Anxiety with depression, insomnia, and poor appetite. Weight gain is reliable.
Hydroxyzine	Antihistamine	PRN anxiety or benzodiazepine alternative in SUD history. Anticholinergic.
Propranolol	Beta blocker	PRN for performance situations. Blunts the peripheral autonomic signs. Little for generalized or panic.
Gabapentin, pregabalin	Gabapentinoid	Off-label in anxiety, particularly social anxiety and PTSD-associated. Some misuse liability.
Quetiapine XR	Atypical antipsychotic	Refractory GAD or when comorbid mood symptoms need coverage. Metabolic effects.
Imipramine, clomipramine	TCA	Panic (imipramine) and OCD (clomipramine). Anticholinergic burden, cardiac risk.

Special considerations

- Pregnancy: sertraline is the most-studied SSRI. Paroxetine is avoided in the first trimester. Benzodiazepines late in pregnancy carry neonatal withdrawal and floppy infant risks.
- Older adults: benzodiazepines are on the Beers list. Buspirone, sertraline or escitalopram at lower doses, and mirtazapine are the workhorses. Avoid hydroxyzine (anticholinergic).
- Bipolar history: SSRIs and SNRIs used for anxiety in undiagnosed bipolar can trigger mania. Screen first.
- SUD: avoid benzodiazepines when possible. SSRI, SNRI, buspirone, hydroxyzine, gabapentin (with caution) are the choices.
- Panic disorder: start at half the usual antidepressant dose. Panic patients are sensitive to activation.
- Chronic benzodiazepine use: taper is possible but slow (months to years). Cross-taper to diazepam or clonazepam is a common approach.

What tips the choice

Chronic anxiety with no red flags: SSRI or SNRI. Sertraline or escitalopram default. Panic: SSRI or SNRI, start low. Social anxiety: SSRI or venlafaxine XR, plus propranolol PRN for performance situations. GAD only and mild: buspirone monotherapy is reasonable, especially with sexual side effect concern. Depression comorbid: SSRI or SNRI covers both. Avoid bupropion monotherapy if anxiety is prominent. Insomnia comorbid: mirtazapine, or SSRI plus trazodone at bedtime. SUD history: avoid benzodiazepines. Older adult: sertraline or escitalopram at lower doses, or mirtazapine.

Watchouts

- Anxiety often worsens in the first 1 to 2 weeks on an SSRI or SNRI. Start low, warn the patient, and it usually passes.
- Benzodiazepine risks: tolerance, dependence, cognitive effects, falls in older adults, and overdose potential combined with opioids or alcohol.
- Chronic benzodiazepine use interferes with the extinction learning that anxiety treatment relies on. It's often the reason patients get stuck.
- Buspirone does not work for panic disorder.
- Bupropion monotherapy is a poor early pick when anxiety is prominent.
- Serotonin syndrome risk with combinations: tramadol, triptans, dextromethorphan, lithium, St John's wort.

Reviewed against current guidelines as of June 8, 2026. Educational reference, not medical advice.