

# CONCEPT OF GENERALIZED ANXIETY DISORDER (GAD) IN UNANI MEDICINE

## Abstract

Generalized Anxiety Disorder (GAD) is a common mental health condition marked by an abundance of unmanageable concern, accompanied by various physical and cognitive symptoms. This chapter delves into the historical roots of GAD within the framework of Unani Medicine, exploring its definitions, classification, epidemiology, etiopathogenesis, clinical features, comorbidities, differential diagnosis, and management strategies. Special emphasis is placed on the Unani concept of GAD and its traditional principles of treatment.

The historical perspective of GAD within Unani Medicine provides insights into the evolution of diagnostic criteria and therapeutic approaches. Unani Medicine, deeply rooted in ancient Greek and Islamic medical traditions, has a rich history of recognizing psychological conditions, including anxiety disorders, and developing holistic treatment methodologies.

Various Unani physicians have contributed to the understanding of GAD. Their definitions highlight the interconnectedness of mind, body, and environment. This chapter reviews how different Unani scholars have classified GAD based on its etiology, clinical presentation, and psychosomatic aspects.

An exploration of GAD's prevalence in different populations, as seen through the lens of Unani Medicine, provides cultural and geographical insights into the disorder's manifestation. This analysis contributes to a broader understanding of the global burden of GAD.

Unani Medicine offers a unique perspective on the etiopathogenesis of GAD, attributing it to imbalances in the humoral and temperamental factors. This chapter investigates

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how Unani concepts like "su-e-mizaj" (maltemperament) and saudavi mizaj (melancholic temperament) influence the development of GAD.

By aligning Unani descriptions of GAD symptoms with modern clinical criteria, this chapter highlights the intricate symptomatology described in classical texts. Additionally, it explores Unani insights into the frequently observed comorbidities that accompany GAD.

Unani Medicine's differential diagnosis framework for GAD distinguishes it from similar conditions, emphasizing the importance of understanding underlying causes and individualized diagnostic approaches.

The chapter reviews Unani pharmacotherapies and psychotherapeutic interventions for managing GAD. It underscores the integration of herbal formulations, dietary adjustments, and cognitive-behavioral techniques as integral components of holistic care.

Unani principles of treatment, encompassing the enhancement of "su-e-mizaj" and elimination of morbid humors, are explored within the context of GAD. The chapter investigates the role of dietary management and environmental modifications in restoring balance.

In conclusion, this comprehensive chapter bridges the historical legacy of Unani Medicine with contemporary understanding of Generalized Anxiety Disorder (GAD). By contextualizing the disorder within the Unani framework, the chapter sheds light on the intricate interplay between psychological, physiological, and environmental factors. Insights into the etiopathogenesis and management of GAD from an Unani perspective offer a holistic approach that may complement modern therapeutic modalities.

**Keywords:** Anxiety disorder, Medicine, etiopathogenesis, Unani, GAD

## I. INTRODUCTION

The history of psychiatric disorders begins with the existence of human history. Mental disorders prevailed even in the pre-historic era. The skulls with marks of trephining from different parts of the world are the strong evidence of psychosocial illness that prevailed during pre-historic era. These are considered to be 5000- to 10000 years old. The holes in the patients' skulls were meant to let out the evil spirits which were believed to cause illness and afflictions.(1) The oldest note we found is the document known as the Ebres Papyrus (About 1500 BC). It appears to describe concentration disorder and emotional distress in the heart or mind. Some of these interpretations resemble the description of hysteria and melancholy.(2)

When medical thought flourished, from 500 BC to 500 AD, scientific inquisitiveness was nurtured and it was led by Hippocrate, The Father of Medicine. He was the first man of the scientific spirit. He presented many theories and principles of medicine. He was the first to reject the idea of evil, demon, and superstition. The large-scale accepted theory of four bodily humours was the idea of Hippocrates. He established medicine as a science and offered the idea of pathology in scientific temper. He put forth the concept of psychosomatic diseases. As per his writings, body and minds are inseparable. Every somatic disease has inevitable psychological implications and vice-versa. No any disease is purely either somatic or psychiatric. Consideration of mental health has therefore been an integral part of holistic healing. His immortal contribution to the medical field is the humoral theory. According to Hippocrates, health and body functions are the virtue of four bodily humours. The diseases, including mental disorders, were caused by an imbalance in these four body humours, whether qualitative or quantitative. Based on humoral theory, he categorized the mental disorder into three viz a viz; melancholia, mania, and phrenitis. He had a clear concept of environmental factors, diet, and living habits in disease causation. He was even aware of water, its qualities, and its impacts on the body and health. He advocated non-pharmacological interventions of diseases and maintained appropriate diet, healthy lifestyle to cure the diseases.(3)

Plato (427-437BC) was the first to advocate that any illness is the result of an imbalance between the soul (psyche) and the soma (body). He divided the psyche or soul into three parts; appetite, impulse, and reason; and the seats for these three are in the abdomen, chest, and head, respectively.(4)

Aristotle (384-322 BC), the disciple of Plato, disagreed with the theory of divinely caused mental illness given by Plato. He recognized Hippocrates' humoral theory and asserted that 'qalb' (the heart) was the primary hub for all mental functions, making it the principal origin of causation for mental disorders. (4)(5) (6)

Galen (130-205 AD) of Rome followed the footstep of Hippocrates and defined several syndromes, including dysthymia, paranoia, and the impact of sexual excitement and anxiety in hysteria. He perceived that a state of physical and emotional well-being depended on the equilibrium of the circulating "humours." According to Galen's theory, it was believed that not expelling human semen or uterine secretions could result in anxiety.(4)(5)(7) (6)

Rabban Tabari, in his book "Firdausul hikmah," has vividly described psychological illnesses into 13 types such as sa'ra (epilepsy), waswasah, hizyan (hallucination), fasad-e-

khayal, fasad-e-aql, nisyan (amnesia), bedaari (insomnia), kasrat-e-neend, dawi (tinnitus), duwar (vertigo).(8) Rhazes adopted the same classification in his book "Kitabulfakhir".(9)

Another scholar Al-Farabi emphasized on the therapeutic effect of music on the soul. He mentioned the therapeutic importance of music in healing of psychosocial disorders.

Al-Majusi (930-994 AD), in his masterpiece 'Kamil-us-Sina'ah', gave a clear account of mental diseases, including sleeping sickness, loss of memory, hypochondria, and lovesickness.(10)

The Unani medicine has very vast literature on mental illness. Mental illnesses such as melancholia (malekholia), subara, qutrub, schizophrenia (junoon), insomnia (sahar), nightmares (kaboos), and erotomania (ishq) were documented over a millennium ago.(11–13)

Izterab-e-nafsaniumoomi (GAD) was not a separate entity until the 19th century. Therefore, no any description with this nomenclature is available in ancient text. However, the features of mental stages of melancholia resemble GAD.

Historically, anxiety states were first labeled in the cardiovascular chapters. Da Costa gave the classic description of the syndrome that he called "irritable heart" in 1871.(14)

Anxiety disorders were absent from the categorization of psychiatric conditions until the latter half of the 19th century. The reason behind this is that the classification during that period was made on the basis of patients entertained exclusively in psychiatric hospitals.

Beard, only in 1869, coined the term neurasthenia, when the minor degree of anxiety was clustered with minor depressive disorders. Afterward, Hecker detected that half of his neurasthenia patients suffered from panic attacks spontaneously or in specific situations. After that, he provided a detailed explanation of anxiety episodes, citing palpitations, rapid breathing, vertigo, sweating, and frequent urination as symptoms. Firstly, Westphal identified anxiety disorder in 1871 and defined the syndrome of agoraphobia. In 1895, Freud differentiated anxiety disorders from neurasthenia and proposed the name "anxiety neurosis." The term included simple phobia, agoraphobia, generalized anxiety disorder, and panic attacks.(6)

The hallmarks of anxiousness are two characteristics. In general, it is an unsettling feeling that is futuristic. It can be distinguished from dread because there isn't a clear source of danger or because the feeling is out of proportion to the stimulus that causes fear. Numerous anxiety measures have been used since the term "anxiety" has a broad definition. These include physiologic indicators of anxiety, such as the galvanic skin response, heart rate, and perspiration production, as well as self-reports of symptoms and mental anguish and judgements of anxiety by observers. These evaluation methods have been used to differentiate between healthy and abnormal anxiety. The subjective opinion of the patient that the symptoms are more frequent, more intense, or more persistent than he is used to or can tolerate is how Lader characterises pathological anxiety.(15)

## II. DEFINITION AND CLASSIFICATION

It is not easy to discuss Anxiety (Tashweesh or Izterab-e-Nafsani) logically. The reason is that information is incomplete in many areas of normal and abnormal emotions and the associated biological mechanisms. Starting with the fundamental nature of anxiety, there is uncertainty.(16)

A broad, uncomfortable, nebulous sense of uneasiness that may or may not be accompanied by autonomic symptoms is what is meant by the term anxiety. The term anxiety is derivative of the word "anxitas," meaning "troubled in mind". Normal anxiety signals an individual impending danger and empowers one to take precautionary or corrective actions. Pathological anxiety is characterized either by an overstated response to stress or anxiety in the absence of stress.(16)

Within Unani medicine, psychiatric conditions are intricately elaborated upon under the category known as "amraz-e-nafsaniya," which delineates a range of symptoms related to the mental faculties and their disruption resulting from the influence of imbalanced humours, notably "safra" and "sauda."(17,18) Anxiety disorders, as a specific category, are not explicitly mentioned in Unani literature. However, their symptoms are individually or in conjunction with other distinct ailments described under various headings such as "malekholia," "waswas," "mania," "sahar," "tawahhush," "hizyan," "ishq," and "khafqan."(18)(19)(8)(20)

**1. The Dictionary Meaning of Anxiety in the Context of Unani Medicine, are as follows:** The Arabic language has the word "Izterab," a synonym of anxiety in Arabic.(21) Izterab was given the suffix "Nafsani" by the Unani scholars, signifying its psychological roots. Izterab-e-nafsani, then, is the Arabic word for worry, fear, and overthinking. Additionally, it expresses the impression of interference with ordinary labour.(22)

**Tashweesh:** It is a Persian word, and it means difficulty in doing any work. In other words, it is Noun, (ism) masculine (muzakkar), and it means restlessness and worry.

The most commonly experienced emotion is that of anxiety. Apart from the pathologic, the experience of anxiety is necessary to survival. Anxiety is the positive emotion that arises from inside when there is a risk to one's well-being or interests. Fear and anxiety feel the same concerning the subject, but they are different objectively. When the threat of an identifiable external danger in the environment causes anxiety, the term fear is used. Thus, fear is most important in alarming the individual to get ready for protection by taking proper measures. The risk of the loss of a job causes fear, and anxiety is its result.(16)(23–26)

**2. Modern Concept of Anxiety:** Anxiety is a common emotional state that is necessary for effective functioning and fending off a dangerous circumstance. When normal anxiety results in considerable subjective distress and/or functional impairment, it is referred to as pathological anxiety. Today's fast-paced lifestyle and challenging competitions have made anxiety disorders a common ailment in society. The patient experiences something

akin to fear or trepidation as a result of ANS disturbance (Sympathetic overactivity).  
(16)(24)(27)(28)

- 3. Different Authors Defined Anxiety in their Books as follows:** "Anxiety is characterised by a variety of somatic and autonomic symptoms as well as a subjective experience of dread or fear about the present or the future. As a symptom, it occurs in several disorders. In anxiety disorders, anxiety occurs as a primary, most severe, and prominent symptom without any underlying organic illness or another psychiatric illness".(2)(29)

"Anxiety states often present with somatic symptoms related to autonomic nervous system arousal or sympathetic overactivity or to psychic symptoms or both, which includes nervousness, fearfulness, sleeplessness, dyspnea, chest pain, gastrointestinal distress, and others. The anxiety may be free-floating or situation-dependent, as in phobic disorders, e.g., agoraphobia and other phobias".(27)(30–32)

"Anxiety is a future-focused mood state in which one feels ready or prepared to make an effort to cope with impending unpleasant events, implying that the difference between anxiety and fear is between impending vs. present danger".(3)

"Anxiety is regarded as a typical response to stress. By encouraging one to deal with it, it might assist someone in handling a challenging situation, like one at work or at school".(14)

### III. CLASSIFICATION

It wasn't until the late eighteenth century that the anxiety disorders were described as distinct conditions. So, sorting things out wasn't a simple process. It became contentious, and DSM-III reflects this. However, ICD-10 and DSM-IV have somewhat corrected this reasoning. There are still some distinctions between DSM-V and ICD-10 in terms of classification. The following categories apply to anxiety disorders in DSM-V:(33)

Separation Anxiety Disorder  
Selective Mutism  
Specific Phobia  
Social Anxiety Disorder (Social Phobia)  
Panic Disorder/Panic Attack Specifier  
Agoraphobia  
Generalized Anxiety Disorder  
Substance/Medication-Induced Anxiety Disorder  
Anxiety Disorder Due to Another Medical Condition  
Other Specified Anxiety Disorder  
Unspecified Anxiety Disorder  
The ICD-10 has the following classification:(34)  
Neurotic, stress-related, and somatoform disorders  
**F40 Phobic anxiety disorders**  
F40.0 Agoraphobia  
.00 Without panic disorder  
.01 With panic disorder

F40.1 Social phobias

F40.2 Specific (isolated) phobias

F40.8 Other phobic anxiety disorders

F40.9 Phobic anxiety disorder, unspecified

**F41 Other anxiety disorders**

F41.0 panic disorder [episodic paroxysmal anxiety]

F41.1 Generalized anxiety disorder

F41.2 Mixed anxiety and depressive disorder

F41.3 Other mixed anxiety disorders

F41.8 Other specified anxiety disorders

F41.9 anxiety disorder, unspecified

**F42 Obsessive-compulsive disorder**

**F43 Reaction to severe stress and adjustment disorders**

F43.0 Acute stress reaction

F43.1 Posttraumatic stress disorder

F43.2 Adjustment-disorders

.20 Brief depressive reaction

.21 Prolonged depressive reaction

.22 Mixed anxiety and depressive reaction

.23 With the predominant disturbance of other emotions

.24 With the predominant disturbance of conduct

.25 With mixed disturbance of emotions and conduct

.28 With other specified predominant symptoms

F43.8 Other reactions to severe stress

F43.9 Reaction to severe stress, unspecified

It is clear that the ICD-10 divided anxiety disorders into two major categories, namely phobic disorders and other anxiety disorders. Then, both are divided. The five phobias are agoraphobia, social phobias, isolated phobias, other phobia-related anxiety disorders, and undefined phobias. Other mixed anxiety disorders, depressive disorder, other specified anxiety disorders, panic disorder (episodic paroxysmal anxiety), generalised anxiety disorder, mixed anxiety, and anxiety disorder unspecified are the other six anxiety disorders.

Under the category of disorders resulting from extreme stress and disorders of adjustment, mixed anxiety and depressive disorders are listed separately.

There are four significant variations between the Diagnostic and Statistical Manual (DSM-V) and the International Classification of Diseases (ICD-10). Phobic anxiety disorder and other anxiety disorder are the two identified subgroups for anxiety disorders in the ICD-10. Phobia disorders fall under the category of anxiety disorders in the DSM-V. OCD is classified as an anxiety disorder in the DSM-V. Obsessive-compulsive disorder (OCD) is not included in the category of anxiety disorders in ICD-10 since OCD and anxiety disorders are classified separately. DSM-V does not have a category for mixed anxiety and depression, however ICD-10 does.

Some different authors categorized the anxiety disorder in the following way.(6)(24)(35)

- 1. Normal or Healthy Anxiety:** The majority of people experience this sort of good anxiety as a result of unwelcome stressors in daily life, such as exams, interviews, and other situations. It is a typical response to an extraordinary circumstance.
- 2. Pathological or Morbid Anxiety:** This type of anxiety is an unwarranted reaction to a stimulus of a certain intensity or length. Equally pathological to extreme anxiety is the complete lack of anxiety. The patient is well aware that his anxieties are absurd, illogical, and unfounded, yet this does not help him because he intensifies, examines, and is powerless to control his uneasiness.
- 3. Trait Anxiety:** This is a propensity to consistently feel nervous.
- 4. State Anxiety:** This type of anxiety refers to the worry experienced in the here and now, or in a cross-sectional situation.

#### IV. EPIDEMIOLOGY

Before specific diagnostic criteria were developed in 1973, Marks and Lader investigated the epidemiology of anxious states. The prevalence of anxiety states was higher in women than in males, especially among younger women (16–40 years old). 30% of women and 19% of men have an anxiety disorder throughout their lifetime, according to the DSM.(15)(32)

In the general population of the United States, generalised anxiety disorder affects 2.9% of adults and 0.9% of adolescents over the course of a year. The disorder's 12-month prevalence in other nations ranges from 0.4% to 3.6%. A 9.0% lifetime morbid risk exists. The prevalence of generalised anxiety disorder in women is double that in men. The prevalence of the diagnosis is highest throughout middle age and gradually decreases as people age. People from industrialised nations claim to have dealt with the symptoms of generalised anxiety disorder more frequently than people from less developed nations.(33)

Anxiety disorders, which can affect 15% to 25% of the general population, are the most common mental disorders, accounting for up to 30% of all cases. (36–38)

With a lifetime prevalence of 4–7% in the general population, GAD is the most common anxiety disorder in the primary care environment. (39–41)

Incidence rates are higher among singles than married people, members of minority racial groups than members of dominant racial groups and members of majority NDCI, as well as respondents with lower socioeconomic position (SES) than respondents with middle or higher SES.(42)

Social functioning is typically poor in GAD patients. More than one-third of the GAD patients in the Harvard Brown Research Programme (HARP) study had never married. (43,44)

Additionally, patients had lower levels of employment than the overall population.(44)



20% of parents and 10% of siblings of anxiety sufferers have been shown to have anxiety disorders. Due to a lack of data and ambiguous diagnostic criteria, the evidence for a genetic or constitutional predisposition to anxiety is still insufficient. (45)

The India State-Level Disease Burden Initiative's initial comprehensive report is awful. It demonstrates that a sizeable fraction of the population in India experiences mental illnesses of varied degrees of severity, such as depression, anxiety disorders, schizophrenia, bipolar disorders, idiopathic developmental intellectual disability, conduct disorders, and autism. The share of mental diseases to the overall disease burden has doubled between 1990 and 2017 in just 27 years. India had 197 million people with mental illnesses in 2017; of these, 46 million had depression and 45 million had anxiety disorders. The Lancet published the report. (46)

## V. ETIOPATHOGENESIS

The four humours (Akhlāt-e-Arba), an antiquated medical theory or notion, serve as the foundation for both health and disease in the Unani school of medicine. According to the facts of the disease's etiopathogenesis, any one of the four humours may be out of balance, or there may be a combination of more than one humours. Similar to how personality types in a certain person were determined by the dominating humour. (47)

A fundamental notion regarding the origin of diseases is stated in the literature of unani medicine. Three fundamental components are the root causes of all diseases. They are discontinuity of tissues (tafaruq-e-ittisal), altered temperament (su-e-mizaj), and altered structure (su-e-tarkeeb). They are both many factors in the next subdivision and groups of factors. (48,49)

Mizaj is a concept that only exists in unani medicine. The normal Mizaj is the distinct and precise reflection of neuroendocrine, genito-metabolic, and environmental equilibrium at the best degree of functional adjustment. (50) The derangement in this discrete state subsequently causes disease conditions. (51) The change in the composition of four properties, i.e., haraarat (hotness), baroodat (coldness), ratoobat (moistness), and yaboosat (dryness), can alter the mizaj. It is known as sue mizajsada. If this imbalance affects akhlāt (body fluids/humours), it is called sue mizaj maddi. (52) Both conditions produce pathology and affect the faculties.

According to the notion of humours, the body contains four humours: blood, phlegm, yellow bile, and black bile. According to the variety of humour they include, the words damwi (sanguine), balghami (phlegmatic), safrawi (choleric), and saudawi (melancholic) are the mizaj of various people. (53)

Psychic faculties (quwwat-e-nafsania), vital faculties (quwwate-e-haivania), and physical faculties (quwwate-e-tabiiyya) are the three main quwa (faculties) of the human body. These quwa (faculties) are necessary for the specialised operations of that organ. Quwwatetabiiyya has the abilities to support growth, reproduction, and nutrition. This quwwat is led by the liver/jigar. When performing tadbeer of rooh, Quwwatehaiwaniya. The rooh gives the thing it supplies life. This faculty is centred on the heart. The brain is thought to be the seat of the intellect, sensory, and motor faculties that Quwwat-e-Nafsania is concerned with. (20) (54,55)

Quwae nafsania, or the mental faculties, manage the body's intellectual, sensory, and motor processes. It serves as a genus for them and has two primary faculties. These are quwae-e-muharrakah (motor faculties) and quwae-e-mudrikah (perceptive cognitive faculties). In addition, there are two varieties of quwa-e-mudrikah (perceptive cognitive faculties): quwa-e-mudrikahzahira (external perceptive faculty) and quwa-e-mudrikah batinah (interior perceptive faculties). We'll talk about internal perceptual faculties, which are involved with how the brain thinks. (20)(54,55)(48)

Ibn Sina (Avicenna) and his followers categorized the internal perceptive faculties in following five: (20)(54,55)(48)

1. Faculty of composite sense (Al-hiss al-mushtarak)
2. Faculty of imagination (Al-khayal)
3. Faculty of apprehension (Al-wahimah)
4. Faculty of memory (Al-hafizah)
5. Faculty of ideation (Al-mutasarrefah)

The faculty of al-hiss al-mushtarak is where all feelings come together, are integrated with one another, and then a united action occurs. Quwat al-khayal performs the memory and maintenance of the configurations of the items. These details and their implications are examined in Quwwat Al-wahimah. The meanings are stored in Quwat al-hafizah. Quwat al-mutasarrefah generates imaginative and abstract concepts. (20)(54,55)

For example, the forebrain, midbrain, and hindbrain are designated as the quwwat-e-takhayyul (faculty of thought), quwwat-e-fikr (faculty of thinking), and quwwat-e-zikr or hafiza (retentive faculty), respectively, by unani scholars. (19)(10)(22)(54,55)

The forebrain's disease is what causes delirium and altered cognitive patterns, according to Ibn Zuhar's Kitab al-taiseer. The patient's thoughts begin to turn negative. Minor midbrain pathology can have major repercussions, such as excessive thinking and mental abnormalities that prevent the brain from making an accurate judgement. (56)

The brain is susceptible to influence when having a cold or wet disposition. Brain disorders are either primary due to abnormal brain behaviour or secondary due to involvement of the brain's neighbouring organs, such as the heart, stomach, liver, etc. The upward flow of stomach gases during an intense fever can potentially have an impact on the brain. An anomaly of the brain may occasionally result from inflammation of the diaphragm or the cardiac end of the stomach. (9)(17)(56)

Ibn-e-Rushd asserts that three different sorts of defects—faculty cessation (Butlaan), faculty deficiency (Nuqsaan), or changed and exaggerated functioning (Tashweesh)—are likely to manifest in the brain. For various illnesses, there are numerous reasons. These faculties may stop functioning or become inadequate due to an abnormally cold and wet temperament or an abnormally cold temperament solely. Due to the obstruction caused by this aberrant temperament within the veins and tubes, the rooh does not adequately penetrate the brain. (19)(17)

These abilities have a different and faulty functioning because of abnormal temperament brought on by safra (bile) or sauda (black bile). People with a predominance of the bilious temperament are more likely to suffer from sleep disorders, coordination issues, dementia, and abnormal/vicious thoughts. (17)

Malekholia, the primary name for the condition, is brought on by abnormal black bile. Palpitations, tension, grief, pain, erroneous perceptions, and a dread of unidentified objects are some of its characteristics.

Distinguished "Anxiety" has been used by unani doctors to describe melancholy. It develops as a result of humoral abnormalities like an overproduction of bile or black bile (sauda or safra). Any one of the four humours can ultimately burn due to excessive bodily heat or its own heat, turning it into aberrant black bile (Ghair tabayi sauda).(10)(13)(22)(57–59)

A disturbance of quwwat-e nafsaniya is one of the causes that various unani physicians have mentioned in addition to humoral derangement. Epilepsy, hepatic and splenic illnesses, a lack of quwwat-e-jaziba and quwwat-e-dafiya, and excessive fear are a few more factors. As a general aetiology of this condition, sadness-like factors are also included. Additionally, diets that produce black bile (sauda), as well as foods such dried spicy meat, sheep, ass, fox, rabbit, and pig meat, are to blame for this condition..(10)(18)(60)

The precise mechanism of GAD is still poorly known in modern medicine. The development of GAD has been linked to biological, environmental, and psychological factors, according to researchers. (10)

## VI. CLINICAL FEATURES

Till the late 19th century, GAD lacked a defined identity and independent mention. Thus, there is no information about GAD specifically in the literature of unani medicine. When we attempted to correlate and search for current GAD, we discovered a wealth of literature with comparable clinical characteristics and aetiologies. As a result, we may assert that Unani medical experts were aware of psychiatric conditions, including GAD. The pathophysiology, clinical characteristics, and management have all been clearly stated. In the Unani system, malekholia's early stages are eerily similar to GAD. Ibn-e-Sina describes malekholia as having "apprehensions, unrealistic fear, short temper, fondness of loneliness, palpitations, dizziness, and tinnitus as signs and symptoms of early-stage melancholia."(10)

In Razi's words, "Suffering from worry, apprehension, sadness along with the appearance of irrational thoughts, is suggestive of the initial stage of malekholia." are the characteristics of the early stage of malekholia.(18)

The primary signs and symptoms of this illness are: (10)(19)(10)(22)(61)(62)

- Fearfulness
- Excessive worry
- False perceptions
- Low self-esteem

- Vague sense of apprehension
- Social isolation and loneliness
- Lack of interest in virtually all activities
- Irritability
- Heaviness in chest
- Restlessness
- Insomnia
- Irregular small and slow pulse.

Psychiatric diseases are mostly brought on by pathology in the brain, though they can also develop as a result of problems with the heart, stomach, liver, or spleen. As is well known, rooh-e-nafsaaniya is first created by the heart as rooh-e-haivaaniya, which is then processed by the brain into rooh-e-nafsaaniya. It now serves the purpose of quwwat-e-nafsaaniya.(10)

The heart is the source of all of the body's functions, according to the eminent philosopher Arastu. This may be the cause of the presence of cardiovascular symptoms, particularly palpitations, in the majority of psychiatric illnesses.

Izterab-e-nafsani umoomi also exhibits certain gastrointestinal symptoms.(22)

- Pain in abdomen
- Indigestion
- Nausea and vomiting
- Burning sensation in epigastria
- Abdominal distention
- Flatulence
- Constipation
- Diarrhea

The majority of quwa-e-nafsaniya acts are the result of sensory experiences coming from sensory receptors like the visual, auditory, and other types of receptors (aza-e-mudrikahzahirah).(55) Therefore, in addition to the aforementioned symptoms, this disease also exhibits manifestations connected to the motor and sensory organs, such as: (10)(19)(10)

- Giddiness
- Tremors
- Tinnitus
- Delusion
- Hallucination
- Blurring of vision
- Ringing in ears
- Headache

Frequent, persistent, and irrational worry is this syndrome's key characteristic (GAD), according to DSM-V. Patients struggle to keep their fear under control. Excessive anxiety about trivial issues has negative consequences on one's quality of life.(53)

Although GAD can cause any of the anxiety symptoms, a typical pattern includes them all. Worry and apprehension, which are prevalent and not specifically targeted symptoms of GAD. The widespread, uncontrollable symptoms are referred to as "free-floating anxiety."(45)

These patients frequently lament their inability to focus, poor memory, impatience, and increased sensitivity to noise. Poor focus might make memory problems feel worse. If true memory loss is discovered, a thorough investigation for a factor other than anxiety should be conducted. A tight face, furrowed brow, dilated pupil, widely opened eye, horizontal creases on the forehead, severe posture, restlessness, and sweating (particularly from the hands, feet, and axillae) are all characteristics of these patients. (63)

The physical symptoms and signs of GAD are brought on by the sympathetic nervous system's excessive activity and the skeletal muscles' elevated tension. Restlessness, trembling (tremor), muscular pain, and headaches (often bilateral, frontal, or occipital) can all be symptoms of muscle stress.

Sweating, palpitations, dry mouth, epigastric discomfort (stomach trouble), giddiness, and lightheadedness are signs of autonomic hyperactivity. Dry mouth, excessive wind (flatulence) brought on by aerophagy, borborygmi, and increased frequency of stools (diarrhoea) are typical gastrointestinal symptoms.

Constriction in the chest, trouble breathing in, strangely a feeling of being out of breath, and overbreathing are all frequent respiratory symptoms. Dizziness, tinnitus, headaches, numbness and tingling, carpo-pedal spasms, and precordial soreness are some of its side effects.

The excessive activity of the sympathetic nervous system and the increased tension in the skeletal muscles cause the physical symptoms and signs of GAD. Muscle tension can cause agitation, trembling (tremor), muscular soreness, and headaches (frequently bilateral, frontal, or occipital).

Autonomic hyperactivity is characterised by sweating, palpitations, dry mouth, epigastric discomfort (stomach pain), giddiness, and lightheadedness. Typical gastrointestinal symptoms include dry mouth, excessive wind (flatulence) brought on by aerophagy, borborygmi, and increased frequency of stools (diarrhoea).

Common respiratory symptoms include chest constriction, difficulty breathing in, an odd feeling of being out of breath, and overbreathing. Some of its negative effects include tinnitus, headaches, numbness and tingling, carpo-pedal spasms, and precordial discomfort.(64)

## **VII. ONSET AND COURSE**

Generalised anxiety disorder (GAD) is frequently present and has a long history, sometimes going all the way back to childhood. According to accounts from patients in clinical research and survey responders, GAD typically manifests before the age of 20. Occasionally, patients may report onset occurring after the mid-30s. Stressful life experiences

have a significant impact on GAD in maturity and GAD that develops later in life. The DSM V states that at least six months of symptoms are required for the diagnosis of GAD, however the ICD 10 contains short duration features for diagnosis. The community epidemiological data collected in the epidemiological catchment area (ECA) show that the duration and course of GAD are typically chronic, with episodes commonly persisting for a decade or longer.(65)

**Comorbid Conditions with GAD:** Recent results demonstrate substantial comorbidity with other psychiatric conditions; formerly, GAD was a relatively minor problem unconnected to a high degree of suffering and disability; research indicates that GAD is rarely present in isolation.(16)

According to the NCS, 65% of people with current GAD were also being treated for at least one other condition at the time of assessment. Only roughly one-third of people with GAD have associated mental disorders, making up the "pure" form of the disorder.(66)

The most typical comorbid ailment connected to GAD is major depressive disorder (MDD), which is estimated to affect 42% of people. (44)

Social phobia (23%), dysthymia (22%), specific phobias, panic disorder (11%), post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD) (6.5%) are among the various mental diseases typically associated with GAD. Disorders related to substance misuse are another typical comorbid condition (16%).(67)

Chronic conditions include coronary heart disease, hypertension, asthma, and diabetes mellitus are also highly comorbid with GAD.

## VIII. DIAGNOSIS

Confirming the GAD diagnosis is quite difficult. The diagnosis is extremely challenging due to the patient's extensive list of complaints, resemblance to other psychiatric and medical diseases, and overlap of symptoms. The misery is made worse by the comorbidity of other mental diseases. Healthcare professionals all over the world use two main diagnostic methods to identify GAD in order to address this issue. They are the Diagnostic and Statistical Manual of Mental Disorders (DSM V) and the International Classification of Mental and Behavioural Disorders (ICD 10) respectively. Recent updates to ICD-10 and DSM V have given medical professionals more precise and trustworthy GAD diagnoses.(67)

The diagnostic standards for the diagnosis of GAD have been outlined in DSM V. (53) For at least six months, there must be excessive stress and anxiety about a variety of activities and events. The person finds it difficult to keep the worry under control. Minimum three out of six symptoms must have been present for at least portion of the past six months on more days than not. These signs consist of:

- Feeling restless, tense, or on edge;
- Being easily worn out;
- Having trouble focusing or going blank.
- Irritability

- Tense muscles
- Insufficient or unsatisfactory sleep (difficulty falling or staying asleep).

Although the suggested criteria for the diagnosis of GAD in the DSM IV and ICD 10 are nearly same, the duration of these symptoms varies. The symptoms must be present for six months according to DSM V. The clinical version of ICD 10 has a less strict condition, though, which states that symptoms must have been present for the majority of the days for at least a few weeks at a time and typically many months.(68)

## IX. DIFFERENTIAL DIAGNOSIS

Any psychiatric condition can have anxiety symptoms, although some have more trouble being diagnosed than others. Because anxiety is a frequent symptom of depressive disorders and GAD sometimes contains some depressive symptoms, the distinction between anxiety and depressive illnesses is frequently problematic. It's important to look at the other common co-occurring disorders, such as panic disorder, phobic disorder, and obsessive-compulsive disorder. (68)

Thyrotoxicosis, pheochromocytoma, hypoglycemia, paroxysmal arrhythmias, brain tumours, and temporal lobe epilepsy are examples of physical conditions that resemble the symptoms of GAD. Other organic causes of anxiety syndrome include exposure to toxins, withdrawal from sedatives or alcohol, or stimulant intoxication from caffeine, cocaine, or amphetamines. (69)

## X. MANAGEMENT

There are two main categories for GAD management: Psychotherapies and pharmaceutical treatments

- 1. Pharmacotherapies:** There are currently numerous potent pharmaceutical therapies for GAD. Drugs that have recently been discovered are not only safer and more tolerant than other older medications, but also more effective than placebo. Benzodiazepines, buspirone, tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), and serotonin nor-epinephrine reuptake inhibitors (SNRIs), among other drug classes, are being used to treat various medical conditions.
- 2. Psychotherapy:** The development of a strong therapist-patient relationship is crucial to the success of psychotherapy. The use of distraction strategies and entertainment outlets is beneficial in psychotherapy. Hippocrates emphasised the value of relaxing surroundings, physical activity, a healthy diet, massages, baths, music, and other ways to treating mental illnesses. The likelihood of remission for someone who has stopped taking medication can be boosted by psychotherapy, as can the effectiveness of the medicine. Only the effectiveness of psychotherapy alone or in conjunction with medication is under question. The meta-analysis of data demonstrates that psychotherapy therapies have better long-term efficacy compared to medication. These include cognitive behavioural therapy (CBT), supportive psychotherapy, relaxation training (techniques), counselling, and meditation.

## XI. USOOLE ILAJ AND ILAJ

The treatment plan in the Unani medical system is properly thought out. Each scholar begins by outlining the usool-e-ilaj therapy principle or line of treatment. The prescription or course of action is then written. The main goal of treatment is to improve the patient's condition, correct mizaj, and restore the lost harmony of the humours through the expulsion of excessive and abnormal humours.

For the treatment of Izterab-e-NafsaniUmoomi, unani doctors recommended the following plan of care.

- The eradication of ridiculous humour and the restoration of the patient's mizaj come first.
- Elimination of the root causes.
- Controlling one's diet.
- A pleasant setting.

**1. Improvement of su-e-mizaj and Elimination of Morbid Humors:** It is believed that Su-e-mizaj is the root cause of Izterab-e-NafsaniUmoomi. With the aid of several criteria established by Unani doctors and the proper medications to eradicate that disturbed humour (FasidKhilt), it is required to identify the predominating humour (khilt). Leading Unani doctors believe that excessive black bile (sauda) produced by anxiety needs to be expelled from the body in order to keep the body's humours in balance. With the use of fad and purgatives like Joshanda-e-Aftimoon and Maa'ul Jubn, excretion is possible. (70)(22)

Ta'deel-e-mizaj refers to mizaj normalisation and the restoration of physiological processes. After removing the akhlat-e-raddiyah from the damaged organ, it is performed. With the help of brain tonics, either by themselves or in combination with tadabeer, the abnormal temperament can be restored. (10)(56)(12,56,57)

"Su-e-mizaj haar sada" refers to an excessive accumulation of heat in the body, specifically in the brain. To alleviate this heightened heat in the brain (haraarat-e-dimagh), certain regimens are employed to induce a cooling effect (baroodat). Additionally, medications with cooling properties, like febrifuge (musakkinat-e-hararat), are administered to help counteract this heat.

**2. Removal of Predisposing Causes:** The next critical step is to rule out any additional factors, such as acute fear, stress, physical effort, alcohol, loneliness, etc.

To achieve this, the following actions ought to be taken: (10)(56)(12,56,57)

- Make sure the patients have something to appreciate, like poetry or music, to keep them happy.
- Keep everything in a good mood.
- Make sure the space is quiet, aromatic, and well-ventilated.
- Attend to any liver and spleen-related problems.
- Promote quitting smoking, alcohol, and other vices.



- Encourage sexual behaviour in moderation.
- Suggest staying away from physically demanding work.
- Prevent going to busy, dimly lit, or unclean locations.
- Suggest steering clear of extended stays in hot climates.
- Stress the importance of heart health in controlling anxiety, including the use of energising drugs (mufarreh-e-qalb) and cardiac tonics in the treatment plan.

### 3. Dietary Management: (10)(56)(12,56,57)

- Avoidance of all moallid-e-sauda and Safra (bile and black bile productive) like stale, salty, and stringent food items.
- Intake of light and delicious food items.
- Use of bilious concoctive fruits such as aalo bukhara, orange, lemon, etc.

In addition to that, Unani medicine also offers a number of anti-anxiety medications for the treatment of anxiety disorders. Asrol (*R. serpentine*), Koknar (Poppy capsule), Opium, Kahu (*Lactuca sativa*), Coriander, and Ajwainkhusani (*H. niger*), among others, as well as compound medications like Khameera Khashkhas, Itrifal kishnizi, and Qurs dawa-us-Shifa, include sedative and hypnotic qualities. These medications are excellent for treating anxiety disorders.

Following are the single drugs (Mufradat) and compound drugs (Murakkabat) generally used by Unani physicians: (10)(56)(12,56,57)(57)

Behidana	Quince Seeds	<i>Cydonia oblonga</i>
Khurfa	Purslane	<i>Portulaca oleracea</i>
Kaddu	Pumpkin	<i>Cucurbita moschata</i>
Tabasheer	Bamboo Manna	<i>Bambusa arundinace</i>
Aalu Bukhara	Common Plum	<i>Prunus domestica</i>
Kishneez	Coriander	<i>Coriandrum sativum</i>
Tamar Hindi	Tamarind	<i>Tamarindus indica</i>
Kahu	Lettuce	<i>Lactuca sativa</i>
Khivarain	Cucumber	<i>Cucumis sativus</i>
Bed Mushk	Mushk Willow	<i>Salix capera</i>
Gule surkh	Rose Flower	<i>Rosa damascene</i>
Nilofar	Water Lily	<i>Nymphaea alba</i>
Bekhe Kasni	Wild Chicory root	<i>Cichorium intybus</i>
Unnab	Jujube	<i>Zizyphus Vulgaris</i>
Zarishk	Indian Barberry	<i>Berberis vulgaris</i>
Afsanteen	Worm Wood	<i>Artemisia absinthium</i>
Sana Makki	Mecca Senna	<i>Cassia Angustifolia</i>
Sibr Zard	Aloe	<i>Aloe barbadensis</i>
Aftemoon	Dodder/Cuscuta	<i>Cuscuta reflexa</i>
Badranjboya	Mountain Balm	<i>Melissa parviflora</i>
MaweezMunaqqa	Large Raisin	<i>Vitis vinifera</i>
Ustukhudoos	French Lavender	<i>Lavendula stoechas</i>
Badavard	Cretan Prickly Clover	<i>Fagonia arabica</i>
Gaozaban	Borage	<i>Borago officinalis</i>

Polyherbal formulations used by Unani physicians include Mufarreh Barid, Dawaul Misk Moatadil, Joshanda Aftimoon, Majoon Najah, Majoon Lana, Itrifal Sagheer, Itrifal Zamani, Sharbat Ahmad Shahi, Sharbat neelofar, etc.(70)(71)(72)

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