

PSYCHO-SOCIO-DEMOGRAPHIC DETERMINANTS OF ANXIETY AMONG THE YOUNG POPULATION IN THE REPUBLIC OF MOLDOVA

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Abstract

Objectives. Anxiety is one of the most prevalent mental health disorders globally, with a significant impact on health and quality of life. The rising incidence, exacerbated by socio-economic factors and the pandemic context, underscores the need for adaptive prevention and intervention strategies tailored to current societal needs.

Material and methods. This descriptive, cross-sectional study was conducted at the “Nicolae Testemițanu” State University of Medicine and Pharmacy, involving a sample of 424 respondents, calculated using Cochran's formula. Data were collected both online and offline using a questionnaire developed based on a narrative synthesis of the scientific literature. The instrument was validated using the Cronbach's Alpha coefficient (ranging between 0.6 and 0.9). Statistical analysis was performed using IBM SPSS and MS Excel, employing appropriate parametric and nonparametric tests.

Results. The sample consisted predominantly of young individuals (mean age = 22.25 years), mostly female (60.4%), and from urban areas (56.6%). The majority of participants were unmarried (70.8%) and lived with their parents (40.6%). Gender- and residence-related age distribution differences were observed. Higher anxiety-related quality of life impact scores was reported by females, individuals residing in urban areas, and participants over the age of 25.

Conclusions. The findings indicate an increased vulnerability to anxiety based on sociodemographic characteristics, highlighting the need for targeted interventions aimed at high-risk groups.

Keywords: anxiety, psychosocial determinants, mental health in youth, sociodemographic vulnerability, Health-Related Quality of Life, Eastern Europe

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Introduction

Anxiety is among the most prevalent mental health disorders globally, being widely distributed and significantly impacting overall health status and health-related quality of life (Pedersen et al., 2014). Although anxiety may initially represent a natural adaptive response to environmental stressors and perceived threats, its disproportionate intensity and duration - especially when it interferes with daily functioning, may suggest a pathological manifestation. Pathological anxiety is recognized as a core symptom of anxiety disorders, as classified in both the *International Classification of Diseases*, 11th Revision (ICD-11), and the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (Buckner et al., 2016).

In the context of accelerated social, economic, and technological transformations, anxiety disorders are on the rise, exerting a significant impact on individuals' quality of life and overall well-being. The specialized literature has extensively explored the associations between anxiety and various somatic conditions.

Anxiety is a multidimensional construct, defined by an emotional state of restlessness and diffuse fear, accompanied by physiological and behavioral changes (Pedersen et al., 2014). If left untreated, it may progress into severe forms with substantial consequences for both physical and mental health. Clinical studies report a high prevalence of chronic diseases and increased premature mortality among individuals with severe mental disorders (Scott et al., 2016).

Anxiety negatively affects cognitive processes, attention, learning, academic performance, and work capacity. It has also been shown to alter physiological parameters such as blood pressure, pain tolerance, stress levels, and immune system functioning (Nechita et al., 2018). Moreover, anxiety has been identified as a predictor of depression, is associated with excessive alcohol consumption, impairs decision-making capacity, contributes to migraine onset, and is correlated with dermatological conditions such as psoriasis and atopic dermatitis (Solgajová et al., 2016).

The prevalence of anxiety disorders varies considerably, with global estimates ranging from 3.8% to 25% at the national level, and rates reaching up to 70% among individuals with chronic illnesses. According to data from the Global Burden of Disease study, anxiety disorders rank sixth among the leading causes of disability worldwide (Kandola et al., 2018). Prior to the COVID-19 pandemic, the Anxiety and Depression Association of America estimated that approximately 264 million people were affected by anxiety disorders (Stănculescu, 2022). During the pandemic, prevalence increased significantly. For instance, a cross-sectional study conducted in China in February 2020 reported a prevalence of anxiety disorders of 35.2% (Huang & Zhao, 2020). In the United Kingdom, a report published at the end of April 2020 indicated a substantial deterioration in mental health compared to the pre-pandemic period (Pierce et al., 2020).

According to Ruscio et al. (2017), generalized anxiety disorder (GAD) is more frequently encountered in high-income countries, despite a negative association between GAD and socioeconomic status within countries. These findings underscore the global significance of GAD as a public health issue and highlight substantial cross-national differences in prevalence, severity, and functional impact, suggesting the need for further research. Such discrepancies may be partially explained by greater access to mental health services and more openness to mental health issues in developed societies, in contrast to reluctance or neglect of the topic in low- and middle-income countries. The mental health system in the Republic of Moldova is undergoing a transition

toward a community-based care model, which necessitates the collection of robust data on population mental health. A study conducted in July-August 2022, using a multistage stratified sample (n = 1826) and face-to-face interviews, assessed depressive symptoms (PHQ-2), anxiety symptoms (GAD-2), loneliness (UCLA-3), and mental well-being (WHO-5). Symptom prevalence was 19.8% for depression, 25.5% for anxiety, and 16.1% for loneliness. The average mental well-being score was 69.6 out of 100. Women reported higher levels of depression and anxiety, lower well-being, and increased loneliness compared to men. Older adults and individuals with low incomes also reported higher prevalence of negative mental health symptoms, even after adjusting for education level and occupational status (van Baar et al., 2025).

In this context, understanding and appropriately managing anxiety is essential for promoting mental health. The implementation of effective strategies for prevention, early intervention, and psychological support may significantly reduce the negative impact of anxiety, thereby improving quality of life. Recent findings underscore the need to integrate mental health interventions into public health policies and highlight the critical role of psychological support in maintaining population well-being.

Material and methods

General objective

This study aims to investigate the psychosocial and sociodemographic determinants of anxiety and perceived health status among young populations in middle-income countries, with a particular emphasis on the Republic of Moldova. The overarching goal is to inform the development of evidence-based strategies for the effective management of anxiety in this demographic group.

Research design

The present work constitutes an original, descriptive, cross-sectional study conducted within the “Nicolae Testemițanu” State University of Medicine and Pharmacy. The study demonstrates a high level of methodological rigor and internal validity. The sample size was calculated to ensure both statistical power and representativeness for the target population of young adults, employing Cochran’s formula: $n = d[\tilde{\pi}(1-\tilde{\pi})] * (z\alpha/w)^2 = 424$. In order to achieve a comprehensive and heterogeneous respondent sample, data were collected using both digital (Google Forms disseminated via online communities) and paper-based (distributed in high-traffic public spaces) methods.

Instrument development and validation

The questionnaire was developed by the research team based on a narrative synthesis of the literature identified through searches in international scientific sources, including PubMed/MEDLINE and the Cochrane Library, complemented by relevant peer-reviewed articles. The draft instrument was structured to capture socio-demographic characteristics, attitudes toward anxiety, self-assessed anxiety levels during the previous month, perceived sources of support, and preferred anxiety management strategies. A pilot study was conducted on a subsample of 43 respondents in order to assess the clarity, relevance, and internal consistency of the questionnaire items. Internal consistency was evaluated using Cronbach’s alpha, with coefficients ranging from 0.60 to 0.90 across questionnaire domains, indicating acceptable to good reliability, in accordance with recommended psychometric thresholds (Tavakol & Dennick, 2011). Data obtained from the pilot phase were analyzed using IBM SPSS Statistics, version 28.1 (licensed), and the final version

of the instrument was refined accordingly. The questionnaire design and validation process was informed by previous work on instrument development for related public health topics (Croitoru et al., 2022).

Questionnaire structure

The final version of the questionnaire consisted of 33 questions, structured as follows: Socio-demographic characteristics - 5 questions; Attitudes toward anxiety - 8 questions; Self-assessed anxiety level in the past month and Perceived sources of support and preferred anxiety management strategies— remaining items.

Participants were fully informed regarding the purpose of the study, the estimated completion time of the questionnaire (approximately 10 minutes), their right to withdraw at any stage should any question conflict with their personal values or beliefs, and the assurance of anonymity and confidentiality in data handling and reporting.

For the paper-based version, participant selection adhered to predefined eligibility criteria, including adequate sensory capacity (hearing and vision) and cognitive clarity. Inclusion criteria comprised age over 18 years, emotional stability, and the provision of informed consent. Exclusion criteria included apparent cognitive impairments or explicit refusal to participate. Offline data collection was carried out between June and July 2024, during weekends, in high-traffic public locations to enhance sample diversity and respondent volume. Informed consent was explicitly obtained via a confirmatory response (“Yes”) to the first item of the questionnaire: “Do you agree to participate in this study?”

Data analysis was performed using Microsoft Excel in conjunction with IBM SPSS Statistics software, version 28.0.0.1 (licensed). A combination of parametric and non-parametric statistical tests was employed, as appropriate, to assess the distribution and association of both quantitative variables (e.g., Likert scale items) and categorical (qualitative) responses.

Results

Sociodemographic characteristics of the study sample

The age of participants ranged from 15 to 33 years, with a mean age of $M = 22.25$ years ($SE = 0.21$, $SD = 4.29$), indicating a sample predominantly composed of young individuals and students, yet with moderate variability. The study population was stratified into three age subgroups: (1) under 20 years, 34.0% ($n = 144$; 95% CI [29.6%, 38.6%]); (2) 20–24 years, 40.6% ($n = 172$; 95% CI [36.0, 45.3]); and (3) over 25 years, 25.5% ($n = 108$; 95% CI [21.5, 29.8]), with appropriate statistical significance for representativeness.

The biological sex distribution revealed a predominance of female participants, accounting for 60.4% ($n = 256$; 95% CI [55.7, 64.9]) of the total sample, compared to 39.6% ($n = 168$; 95% CI [35.1, 44.3]) male participants. This suggests that women are more inclined to participate in mental health surveys, potentially reflecting higher levels of awareness and engagement with topics related to anxiety.

Regarding residential background (parental origin and place of birth), the majority of participants were from urban areas, representing 56.6% ($n = 240$; 95% CI [51.9, 61.3]), while 43.4% ($n = 184$; 95% CI [38.7, 48.1]) originated from rural settings.

Marital status at the time of the survey was also considered. Respondents were classified into three subgroups: single, 70.8% ($n = 300$; 95% CI [66.3, 74.9]); married, 27.3% ($n = 116$; 95% CI [23.1, 31.8]); and divorced, 1.9% ($n = 8$; 95% CI [0.9, 3.5]).

Another variable analyzed in this study was the respondents' current living arrangement. Based on the responses, participants were divided into four categories: (1) living with parents,

40.6% ($n = 172$; 95% CI [36.0, 45.3]); (2) renting, 21.7% ($n = 92$; 95% CI [18.0, 25.8]); (3) living with their own family, 19.8% ($n = 84$; 95% CI [16.2, 23.8]); and (4) residing in dormitories, 17.9% ($n = 76$; 95% CI [14.5, 21.8]).

Comparative gender-based analysis

The comparative analysis by biological sex revealed that female respondents demonstrated a greater willingness and openness to participate in anxiety-related research compared to their male counterparts. This finding prompted a detailed examination of the sample's sociodemographic variables by gender.

We observed a higher proportion of females residing in urban areas, 64.1% ($n = 164$; 95% CI [58.1, 69.8]), compared to those from rural areas, 35.9% ($n = 92$; 95% CI [30.2, 41.9]). In contrast, males were more prevalent in rural areas, 54.8% ($n = 92$; 95% CI [47.2, 62.2]), than in urban settings, 45.2% ($n = 76$; 95% CI [37.8, 52.8]).

Additionally, we noted a predominance of males in the 20–24 age group, 40.5% ($n = 68$; 95% CI [33.3, 48.0]), compared to those under 20 years of age, 21.4% ($n = 36$; 95% CI [15.7, 28.1]). Among females, the age group under 20 years was most represented, 42.2% ($n = 108$; 95% CI [36.3, 48.3]), whereas the age group over 25 years accounted for the smallest proportion, 17.2% ($n = 44$; 95% CI [12.9, 22.2]).

Regarding current living arrangements, the majority of respondents resided with their parents, both among males, 38.1% ($n = 64$; 95% CI [31.0, 45.6]), and females, 42.2% ($n = 108$; 95% CI [36.3, 48.3]). Conversely, the smallest proportion of males reported living with their own family, 14.3% ($n = 24$; 95% CI [9.6, 20.2]). Among females, the lowest proportions were found in two subgroups: those living in student dormitories and those renting accommodation, each representing 17.2% ($n = 44$; 95% CI [12.9, 22.2]).

Analysis of marital status within the sample showed that the majority of participants identified as single, both among males, 61.9% ($n = 104$; 95% CI [54.4, 69.0]), and females, 76.6% ($n = 196$; 95% CI [71.1, 81.4]). This finding aligns with the sample's age distribution and contemporary demographic trends indicating delayed marriage among younger populations.

Approximately one-third of male respondents reported being married, 35.7% ($n = 60$; 95% CI [28.8, 43.2]), compared to about one-fifth of females, 21.9% ($n = 56$; 95% CI [17.1, 27.2]), suggesting potential gender-based differences in assuming family responsibilities at earlier ages.

Despite the relatively young age of the participants, a small yet notable proportion reported being divorced: 2.4% of males ($n = 4$; 95% CI [0.8, 5.6]) and 1.6% of females ($n = 4$; 95% CI [0.5, 3.7]). This observation may indicate the presence of psychosocial or economic factors that can affect the stability of marital relationships even within young populations.

Psychosocial determinants of anxiety among youth in the study sample

To assess the perceived state of psychological tension and anxiety, respondents were asked to indicate the frequency with which they felt tense or anxious over the past month, using a 5-point Likert scale. The analysis of mean scores (see Table 1) revealed significant differences based on socio-demographic variables: by biological sex, the perceived level of anxiety was higher among female participants ($M = 3.59$) compared to male participants ($M = 2.59$). This finding is consistent with the scientific literature, which highlights a higher vulnerability to anxiety among women; by area of residence, young people from urban areas reported higher levels of anxiety ($M = 3.40$) compared to those from rural areas ($M = 3.15$), possibly reflecting increased exposure to urban stressors and a faster pace of life; by age group, individuals aged 20–25 years recorded the highest anxiety scores ($M = 3.58$), suggesting a possible association with major transitions in personal, academic, professional, and relational life typical of this developmental stage; by marital

status, higher anxiety levels were observed among married ($M = 3.45$) and divorced individuals ($M = 3.50$), potentially reflecting additional pressures related to family responsibilities or post-separation adjustment; by current living arrangement, the highest anxiety scores were registered among those living in rented accommodations ($M = 3.74$), possibly due to housing instability, lack of familial support, or socioeconomic uncertainty.

Table 1

Distribution of Respondents' Self-Reported Frequency of Experiencing Tension or Anxiety During the Past Month

	Never	Rarely	Sometimes	Often	Very often	<i>M</i>
Total sample	3.8% ($n = 16$) [2.3, 5.9]	13.2% ($n = 56$) [10.2, 16.7]	43.4% ($n = 184$) [38.7, 48.1]	24.5% ($n = 104$) [20.6, 28.8]	15.1% ($n = 64$) [11.9, 18.7]	3.34
Biological sex^a						
Male	4.8% ($n = 8$) [2.3, 8.8]	16.7% ($n = 28$) [11.6, 22.8]	57.1% ($n = 96$) [49.6, 64.5]	21.4% ($n = 36$) [15.7, 28.1]	0	2.95
Female	3.1% ($n = 8$) [1.5, 5.8]	10.9% ($n = 28$) [7.6, 15.2]	34.4% ($n = 88$) [28.8, 40.3]	26.6% ($n = 68$) [21.4, 32.2]	25.0% ($n = 64$) [20.0, 30.6]	3.59
Area of Residence^b						
Urban	3.3% ($n = 8$) [1.6, 6.2]	10.0% ($n = 24$) [6.7, 14.3]	40.0% ($n = 96$) [34.0, 46.3]	28.3% ($n = 68$) [22.9, 34.3]	18.3% ($n = 44$) [13.8, 23.6]	3.48
Rural	4.3% ($n = 8$) [2.1, 8.0]	17.4% ($n = 32$) [12.4, 23.4]	47.8% ($n = 88$) [40.7, 55.0]	19.6% ($n = 36$) [14.3, 25.7]	10.9% ($n = 20$) [7.0, 16.0]	3.15
Age Group^c						
<20 years	5.6% ($n = 8$) [2.7, 10.2]	25.0% ($n = 36$) [18.5, 32.5]	44.4% ($n = 64$) [36.5, 48.1]	13.9% ($n = 20$) [9.0, 20.2]	11.1% ($n = 16$) [6.8, 17.0]	3.00
20–24 years	4.7% ($n = 8$) [2.2, 8.6]	7.0% ($n = 12$) [3.9, 11.5]	37.2% ($n = 64$) [30.2, 44.6]	27.9% ($n = 48$) [21.6, 34.9]	23.3% ($n = 40$) [17.4, 30.0]	3.58
>25 years	0% ($n = 0$)	7.4% ($n = 8$) [3.6, 13.6]	51.9% ($n = 56$) [42.5, 61.1]	33.3% ($n = 36$) [25.0, 42.6]	7.4% ($n = 8$) [3.6, 13.5]	3.41
Marital Status^d						
Single	5.3% ($n = 16$) [3.2, 8.3]	16.0% ($n = 48$) [12.2, 20.5]	38.7% ($n = 116$) [33.3, 44.3]	38.7% ($n = 116$) [33.3, 44.3]	24.0% ($n = 72$) [19.4, 29.1]	3.29
Married	0% ($n = 0$)	6.9% ($n = 8$) [3.3, 12.6]	55.2% ($n = 64$) [46.1, 64.0]	55.2% ($n = 64$) [46.1, 64.0]	24.1% ($n = 28$) [17.1, 32.5]	3.45
Divorced	0% ($n = 0$)	0% ($n = 0$)	50.0% ($n = 4$) [19.9, 80.1]	50.0% ($n = 4$) [19.9, 80.1]	50.0% ($n = 4$) [19.9, 80.1]	3.50
Living Situation^e						
Student residence	10.5% ($n = 8$) [5.1, 18.9]	31.6% ($n = 24$) [22.0, 42.6]	42.1% ($n = 32$) [31.5, 53.3]	5.3% ($n = 4$) [1.8, 12.0]	10.5% ($n = 8$) [5.1, 18.9]	2.74
Rented apartment	0% ($n = 0$)	0% ($n = 0$)	39.1% ($n = 36$) [29.6, 49.3]	47.8% ($n = 44$) [37.8, 58.0]	13.0% ($n = 12$) [7.3, 21.0]	3.74
Living with parents	4.7% ($n = 8$) [2.2, 8.6]	14.0% ($n = 24$) [9.4, 19.7]	41.9% ($n = 72$) [34.7, 49.3]	23.3% ($n = 40$) [17.4, 30.0]	16.3% ($n = 28$) [11.3, 22.3]	3.33
Living with own family	0% ($n = 0$)	9.5% ($n = 8$) [4.6, 17.2]	52.4% ($n = 44$) [41.8, 62.8]	19.0% ($n = 16$) [11.8, 28.4]	19.0% ($n = 16$) [11.3, 22.3]	3.48

Note. Data in cells represent percentages, with frequencies (n) in parentheses, and 95% Confidence Intervals [95% CI] in brackets underneath. M = mean score on a 5-point Likert scale ranging from 1 (Never) to 5 (Very often). For zero values, the frequency was reported as $n = 0$ to maintain consistency. ^a $\chi^2 = 58.45$, $p < .001$. ^b $\chi^2 = 13.17$, $p = .010$. ^c $\chi^2 = 56.13$, $p < .001$. ^d $\chi^2 = 49.02$, $p < .001$. ^e $\chi^2 = 49.02$, $p < .001$.

Based on the aforementioned aspects, psycho-socio-demographic determinants influencing the participants' perceived level of anxiety at the time of test administration can be

identified. The analysis examined responses related to persistent anxiety through the question, “Do you feel that anxiety affects your daily life?” The reported score was $M = 2.90$. Distribution of responses according to demographic variables revealed the following patterns: From the perspective of biological sex, the score was higher among females ($M = 3.11$) compared to males ($M = 2.90$); Regarding place of birth, respondents from urban areas reported a higher score ($M = 2.97$) than those from rural areas ($M = 2.80$); The age group 20–25 years recorded the highest score ($M = 3.28$); Concerning marital status, married ($M = 3.03$) and divorced individuals ($M = 3.00$) reported a more pronounced influence of anxiety on daily activities; With respect to current living arrangements, young people living with hosts indicated the highest score ($M = 3.30$).

Although the observed differences between groups do not always reach statistical significance, the identified trends and determinants of anxiety remain consistent and pertinent for understanding its distribution within the studied population.

Anxiety was reported with high frequency in contexts related to academic or professional activities. Specifically, 70.75% of respondents ($n = 300$; 95% CI [66.17, 75.04]) indicated experiencing anxiety predominantly in university settings or at the workplace. This phenomenon can be explained by the constant pressure to perform and the associated social expectations. Continuous evaluation of individual outcomes contributes to an environment of stress and fear of failure, while uncertainty regarding the fulfilment of expectations from professors, colleagues, or family members may lead to pronounced anxiety.

Additionally, 59.9% of respondents ($n = 254$; 95% CI [55.06, 64.60]) reported experiencing anxious states during important decision-making processes, amid uncertainty and a perceived lack of control over the final outcome. In such situations, cognitive focus often centers on potential risks and adverse consequences, which amplifies emotional reactivity. Novel or unpredictable situations were also identified as anxiety triggers by 46.93% of participants ($n = 199$; 95% CI [42.10, 51.81]), primarily through the activation of psychological defense mechanisms and the elicitation of a physiological “fight or flight” response.

Within academic and professional environments, competition and social comparisons constitute vulnerability factors, accentuating the fear of judgment or failure to meet standards imposed by others. Thus, 28.07% of respondents ($n = 119$; 95% CI [23.84, 32.61]) reported the presence of anxiety symptoms during social interactions, and 15.09% ($n = 64$; 95% CI [11.82, 18.86]) noted a negative influence of anxiety on their daily activities.

The impact of anxiety on academic performance was also considerable. Approximately 29.95% of respondents ($n = 127$; 95% CI [25.63, 37.56]) reported a moderate influence of anxiety on academic results, while 23.82% ($n = 101$; 95% CI [19.84, 28.17]) indicated a significant negative impact. This was reflected in difficulties with concentration and information retention, as well as in impaired ability to establish logical connections. Negative rumination and anticipation of failure may lead to reduced performance, emotional exhaustion, and tendencies toward social withdrawal.

Anxiety also promotes avoidance behaviors as a response to the subjective perception of threat or emotional overload. While avoidance may provide temporary relief, in the long term, it becomes a maladaptive mechanism contributing to the maintenance and exacerbation of anxiety symptoms.

The effects of anxiety extend beyond behavioral and cognitive domains, involving alterations in physiological system functioning. Specifically: Cardiovascular system: anxiety may cause increased heart rate (tachycardia), hypertension, and palpitations; Respiratory system: it can induce rapid and shallow breathing (hyperventilation), potentially resulting in dizziness, shortness of breath, or chest pain, sometimes mistaken for symptoms of a heart attack; Digestive system: anxiety affects gastrointestinal motility and secretions, leading to symptoms such as nausea, abdominal pain, diarrhea, or constipation, as well as the onset or worsening of irritable bowel syndrome; Endocrine system: it triggers excessive secretion of cortisol and adrenaline—stress

hormones, which can adversely influence metabolism, appetite, and glycemic regulation; Immune system: prolonged exposure to anxiety may weaken immune response, increasing susceptibility to infections and delaying healing processes.

Thus, anxiety is not solely an emotional or mental health issue but has complex implications for the individual’s physical health.

Anxiety has a particularly detrimental impact on executive cognitive processes, such as planning, decision-making, and goal-setting which tend to become impaired. Specifically, 23.11% of respondents ($n = 98$; 95% CI [19.18, 27.42]) reported frequent difficulties with concentration, while 36.79% ($n = 156$; 95% CI [32.19, 41.58]) indicated that they occasionally struggle to complete tasks due to impaired focus.

Anxiety disrupts concentration processes primarily through the hyper-activation of the sympathetic nervous system, which keeps the brain in a heightened state of alertness characteristic of the survival response. As a result, attention is diverted from the immediate task toward perceived or anticipated threats. Individuals experiencing anxiety often engage in rumination and negative scenario-building, which significantly deplete the cognitive resources required for sustained focus and performance.

Participants’ responses to the question “*To what extent have the following symptoms (commonly associated with anxiety) bothered you over the past month?*” were assessed using a four-point Likert scale (1–never; 2–sometimes; 3–often; 4–always). The findings are summarized in Table 2, which presents the mean self-reported scores for each symptom, stratified by key socio-demographic characteristics: living environment, biological sex, age group, and marital status. Because anxiety symptom intensity was measured on an ordinal four-point Likert scale, between-group comparisons were performed using nonparametric tests. Differences between two independent groups (biological sex and area of residence) were assessed using the Mann-Whitney *U* test, while comparisons across three independent groups (age group and marital status) were evaluated using the Kruskal-Wallis *H* test. A $p < .05$ was considered statistically significant.

Table 2

Mean Self-Reported Anxiety Symptom Scores During the Past Month, Stratified by Living Environment, Biological Sex, Age Group, and Marital Status

Symptom	Total	Urban	Rural	Male	Female	<20yrs	20–24yrs	>25yrs	Single	Married	Divorced
Numbness or tingling	1.61	1.50	1.76	1.64	1.59	1.50	1.51	1.93	1.61	1.62	1.50
Hot flashes	1.92	1.92	1.91	1.93	1.91	1.64	2.16	1.89	1.81	2.17	2.00
Weakness	2.18	2.35	1.96	1.90	2.36	2.06	2.35	2.07	2.23	2.00	3.00
Inability to relax	2.63	2.75	2.48	2.33	2.83	2.17	2.98	2.70	2.51	2.86	4.00
Dizziness	2.00	1.97	2.04	1.95	2.03	2.03	1.86	2.19	2.01	1.97	2.00
Palpitations	2.32	2.23	2.43	2.24	2.38	2.28	2.40	2.26	2.31	2.31	3.00
Trembling	1.69	1.75	1.61	1.62	1.73	1.61	1.65	1.85	1.65	1.83	1.00
Feeling terrified	1.93	1.95	1.91	1.76	2.05	1.72	2.14	1.89	1.95	1.93	1.50
Feeling nervous	2.82	2.93	2.67	2.60	2.97	2.61	3.02	2.78	2.84	2.72	3.50
Shortness of breath	1.82	1.82	1.83	2.05	1.67	1.81	1.63	2.15	1.77	1.93	2.00
Breathing difficulties	1.77	1.62	1.98	1.98	1.64	1.78	1.56	2.11	1.76	1.79	2.00
Fear of dying	1.74	1.55	1.98	2.38	1.31	1.78	1.42	2.19	1.67	1.86	2.50

Symptom	Total	Urban	Rural	Male	Female	<20yrs	20–			Single	Married	Divorced
							24yrs	>25yrs				
Flushed face	2.00	1.93	2.09	2.10	1.94	1.89	2.00	2.15	1.97	2.10	1.50	
Cold or hot sweats	2.07	2.02	2.13	2.21	1.97	1.83	2.09	2.33	1.99	2.28	2.00	

Note. Values represent the mean self-reported intensity of each anxiety-related symptom, as indicated by participants. Higher scores reflect greater perceived frequency and/or severity of the respective symptom. *p*-values were calculated using Mann-Whitney *U* tests for binary group comparisons and Kruskal-Wallis *H* tests for comparisons across three groups.

Regarding anxiety-related symptomatology, data analysis revealed a high prevalence of clinically relevant somatic and cognitive manifestations: (1) the fear that something bad might happen was reported by 72.64% of respondents ($n = 308$; 95% CI [68.13, 76.83]), indicating a pronounced tendency toward threat anticipation, characteristic of persistent anxious states; (2) sleep disturbances were mentioned by 60.38% of participants ($n = 256$; 95% CI [55.56–65.07]), suggesting a significant impact of anxiety on sleep quality and, consequently, on daytime cognitive and emotional functioning; (3) gastrointestinal discomfort was present in 50.94% of respondents ($n = 216$; 95% CI [46.07, 55.80]), which aligns with existing literature describing a strong bidirectional interaction between the central nervous system and the gastrointestinal tract (the brain–gut axis); (4) A sensation of throat constriction (a lump in the throat) was reported by 29.95% of respondents ($n = 127$; 95% CI [25.63, 34.56]), a symptom commonly observed in anxiety disorders and associated with increased autonomic reactivity; (5) muscle tension, reported by 25.47% of participants ($n = 108$; 95% CI [21.39, 29.90]), may be interpreted as a somatic expression of sustained autonomic nervous system activation in the context of chronic psychological distress.

Analysis of responses regarding anxiety symptoms

Participants' responses were analysed in relation to four key items assessing anxiety-related symptomatology, formulated as follows: *How often do you experience panic attacks?* (Panic attacks); *How often do you experience excessive thoughts that you cannot control?* (Uncontrollable excessive thoughts); *Have you had difficulty concentrating on daily tasks?* (Difficulties with concentration); *How frequently do you feel fatigue or exhaustion associated with stress and anxiety?* (Fatigue/exhaustion).

The items were evaluated using a five-point Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often). The results are presented in Table 3, according to key socio-demographic variables: living environment (urban/rural), biological sex, age group, and marital status.

Comparative analysis revealed higher mean scores for Items 2 (uncontrollable excessive thoughts), 3 (difficulties with concentration), and 4 (fatigue or exhaustion) among young adults residing in urban areas, those who were married, and individuals aged 20–24 years. These results indicate an increased prevalence of both cognitive symptoms (e.g., intrusive thoughts, impaired attention) and physiological manifestations (e.g., fatigue) of anxiety within these subgroups.

Conversely, the highest mean scores for panic attacks (Item 1) were observed among male participants, married individuals, and those aged over 25, suggesting a different anxiety profile characterized by more intense acute episodes in these categories. The descriptive results presented in Table 3 suggest higher mean scores for uncontrollable excessive thoughts, difficulties with concentration, and fatigue or exhaustion among respondents from urban areas, female participants, individuals aged 20–24 years, and married respondents. However, the statistical significance of

these differences should be confirmed using nonparametric inferential tests applied to the raw item-level data.

Table 3

Mean Scores for the Four Anxiety-Related Items, Stratified by Living Environment, Biological Sex, Age Group, and Marital Status

	Total	Urban	Rural	Male	Female	<20 yrs.	20–24 yrs.	>25 yrs.	Single	Married	Divorced
Panic attacks	1.53	1.55	1.50	1.62	1.47	1.42	1.49	1.74	1.48	1.69	1.00
Uncontrollable excessive thoughts	3.03	3.08	2.96	2.76	3.20	2.78	3.16	3.15	2.92	3.28	3.50
Difficulties with concentration	2.90	2.97	2.80	2.57	3.11	2.50	3.23	2.89	2.83	3.10	2.50
Fatigue or exhaustion	3.06	3.22	2.85	2.62	3.34	2.72	3.33	3.07	3.03	3.17	2.50

Note. Higher scores indicate greater frequency of experiencing the respective symptom in the past month. The scale ranged from 1 (*never*) to 5 (*very often*). Between-group differences were tested using the Mann-Whitney *U* test for binary comparisons and the Kruskal-Wallis *H* test for comparisons involving three groups.

Taken together, these results underscore the importance of context-sensitive mental health interventions, tailored not only to symptom type but also to demographic profiles. Preventive strategies in academic and occupational settings should particularly target early-onset cognitive symptoms, while clinical screening protocols may need to be adjusted to capture less overt but clinically significant anxiety manifestations in older or married populations.

Physical manifestations and subjective perceptions of anxiety: changes in eating behavior. Among the physiological and subjective effects of anxiety, alterations in eating behavior were reported by a significant proportion of participants in the present study. Specifically, 73.6% ($n = 312$; 95% CI [69.2, 77.6]) indicated changes in their eating patterns, most frequently an increased appetite, while 26.4% reported a reduced appetite during periods characterized by heightened anxiety.

These behavioral changes can be attributed to complex neurophysiological and psychological mechanisms, the most relevant of which include:

Activation of the sympathetic nervous system. Under conditions of acute stress or anxiety, the body initiates the fight-or-flight autonomic response through the release of catecholamine’s (adrenaline and noradrenaline) and cortisol. This physiological activation may inhibit appetite by temporarily reducing gastrointestinal motility. Conversely, in cases of sustained cortisol release, an increase in appetite may occur, particularly for high-calorie foods, as a form of emotional self-regulation.

Hormonal imbalances. Cortisol, a key hormone involved in the stress response, has orexigenic effects, stimulating both appetite and a preference for sugar- and fat-rich foods that provide transient psychological comfort. Depending on individual vulnerabilities, anxiety may also induce hyporexia (loss of appetite) through dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis.

Psychological coping strategies. Eating behavior may serve as a mechanism for emotional regulation, with some individuals engaging in compulsive eating (emotional eating) as a coping strategy, while others experience temporary psychogenic anorexia due to intensified negative thoughts and psychological distress.

Gastrointestinal disturbances associated with anxiety. Anxiety-related gastrointestinal symptoms (e.g., nausea, abdominal discomfort, or irritable bowel syndrome) may adversely affect eating behavior, leading to food avoidance or decreased meal frequency.

These findings highlight the bidirectional relationship between anxiety and eating behavior, emphasizing the need for an interdisciplinary approach to the assessment and management of affective symptoms in young populations.

The analysis of the data presented in Table 4, reflecting participants' responses to the questions “*Have you noticed changes in your eating habits as a result of anxiety?*” and “*Do you feel that you have adequate support from those around you (family, friends, or professionals)?*”, provides an integrated perspective on the relationship between anxiety symptomatology, changes in eating behaviour, and perceived social support. Statistically significant differences in perceived social support during anxiety were observed by biological sex, age group, marital status, and living situation (all $p < .001$), while no significant differences were found by area of residence ($\chi^2 = 0.02$, $p = .893$).

Table 4

Distribution of Anxiety-Related Changes in Eating Behavior and Perceived Psychosocial Support by Socio-Demographic Characteristics

	Anxiety-Related Eating Changes	Social Support During Anxiety
Total sample	73.6% (n = 312) [69.2, 77.6]	73.6% (n = 312) [69.2, 77.6]
Biological sex^a		
Male	34.6% (n = 108) [29.5, 40.0]	44.9% (n = 140) [39.4, 50.4]
Female	65.4% (n = 204) [60.0, 70.5]	55.1% (n = 172) [49.6, 60.6]
Area of residence^b		
Urban	55.1% (n = 172) [49.6, 60.6]	56.4% (n = 176) [50.9, 61.8]
Rural	44.9% (n = 140) [39.4, 50.4]	43.6% (n = 136) [38.2, 49.1]
Age group^c		
<20 years	37.2% (n = 116) [32.0, 42.6]	28.2% (n = 88) [23.4, 33.4]
20–24 years	41.0% (n = 128) [35.7, 46.5]	43.6% (n = 136) [38.2, 49.1]
>25 years	21.8% (n = 68) [17.5, 26.6]	28.2% (n = 88) [23.4, 33.4]
Marital status^d		
Single	75.6% (n = 236) [70.7, 80.2]	65.4% (n = 204) [60.0, 70.5]
Married	23.1% (n = 72) [18.7, 28.0]	32.1% (n = 100) [27.1, 37.4]
Divorced	1.3% (n = 4) [0.4, 3.0]	2.6% (n = 8) [1.2, 4.8]
Living situation^e		
Student residence	15.4% (n = 48) [11.7, 19.7]	20.5% (n = 64) [16.3, 25.3]
Rented apartment	21.8% (n = 68) [17.5, 26.6]	16.7% (n = 52) [12.8, 21.1]
With parents	44.9% (n = 140) [39.4, 50.4]	39.7% (n = 124) [34.4, 45.2]

	Anxiety-Related Eating Changes	Social Support During Anxiety
With own family	17.9% (n = 56) [14.0, 22.5]	23.1% (n = 72) [18.7, 28.0]

Note. Data represent percentages, with frequencies (*n*) in parentheses and 95% Confidence Intervals [95% CI] in brackets. ^a $\chi^2(1) = 13.60, p < .001$. ^b $\chi^2(1) = 0.02, p = .893$. ^c $\chi^2(2) = 17.65, p < .001$. ^d $\chi^2(2) = 17.19, p < .001$. ^e $\chi^2(3) = 24.75, p < .001$.

Changes in eating behavior in response to anxiety. At the level of the entire sample, 73.6% of respondents (*n* = 312; 95% CI [69.2, 77.6]) reported anxiety-related changes in their eating behavior. This substantial proportion suggests a meaningful correlation between anxiety states and adaptive eating behavior patterns. When analyzed by biological sex, women reported such changes at a significantly higher rate (65.4%; *n* = 204; 95% CI [60.0, 70.5]) compared to men (34.6%; *n* = 108; 95% CI [29.5, 40.0]). This disparity may reflect both a greater susceptibility of women to the somatic manifestations of anxiety and a higher likelihood of acknowledging and articulating behavioral changes.

Perceived social support in the context of anxiety. Similarly, 73.6% of participants (*n* = 312; 95% CI [69.2, 77.6]) reported perceiving support from close contacts (family, friends, or professionals), which may serve as a protective factor against the psychological impact of anxiety. From a gender perspective, women reported higher levels of perceived social support, 55.1% (*n* = 172; 95% CI [49.6, 60.6]) than men, 44.9% (*n* = 140; 95% CI [39.4, 50.4]), potentially reflecting gender-based differences in help-seeking behaviors and emotional receptivity.

Integrative considerations. The observed correlations between anxiety and both eating behaviors and perceived social support underscore the need for a comprehensive mental health approach among young people. Particular attention should be paid to early identification of behavioral changes and the reinforcement of psychosocial support systems. The findings support the development of targeted interventions, sensitive to gender differences, aimed at promoting emotional regulation through adaptive strategies and strengthening both personal and professional support networks.

Analysis of the data presented in Table 5 reveals significant variations in the perceived impact of anxiety on health-related quality of life, depending on socio-demographic characteristics and living conditions. The highest mean scores were observed among women, individuals residing in urban areas, respondents aged over 25, those who were married, and those living in rented accommodations.

Specifically, women reported a greater perceived impact of anxiety on quality of life ($M = 5.83, SE = 0.17$) compared to men ($M = 5.62, SE = 0.18$). Regarding place of residence, participants from urban areas reported higher average scores ($M = 5.87, SE = 0.16$) than those from rural settings ($M = 5.59, SE = 0.20$). In terms of age, respondents aged over 25 years perceived a more pronounced impact ($M = 6.30, SE = 0.23$), followed by those aged 20–24 years ($M = 6.19, SE = 0.18$), in contrast to those under the age of 20 ($M = 4.81, SE = 0.22$).

The perceived impact of anxiety on health-related quality of life differed significantly by age group ($F(2, 421) = 16.02, p < .001$), marital status ($F(2, 421) = 6.22, p = .002$), and living situation ($F(3, 420) = 16.22, p < .001$). No statistically significant differences were found by biological sex ($p = .395$) or area of residence ($p = .267$).

Regarding marital status, married respondents reported a significantly higher perceived impact of anxiety on health-related quality of life than single respondents ($p = .001$). Similarly, participants living in rented apartments reported significantly higher scores than those living in student residences ($p < .001$), with their parents ($p < .001$), and with their own family ($p = .014$). These results highlight the importance of adapting psychosocial support and intervention strategies to the demographic and contextual characteristics of young people experiencing anxiety.

Table 5*Perceived Impact of Anxiety on Health-Related Quality of Life Among Young People*

	<i>M (SE)</i>	<i>SD</i>	<i>95% CI</i>	<i>Mdn</i>	<i>IQR</i>
Total	5.75 (0.12)	2.54	[5.50, 5.99]	6.00	[6.00, 7.00]
Biological sex^a					
Male	5.62 (0.18)	2.35	[5.26, 5.98]	6.00	[6.00, 7.00]
Female	5.83 (0.17)	2.67	[5.50, 6.16]	7.00	[7.00, 8.00]
Area of residence^b					
Urban	5.87 (0.16)	2.46	[5.55, 6.18]	7.00	[7.00, 8.00]
Rural	5.59 (0.20)	2.65	[5.20, 5.97]	6.00	[6.00, 7.00]
Age group^c					
<20 years	4.81 (0.22)	2.64	[4.37, 5.24]	5.00	[5.00, 6.00]
20–24 years	6.19 (0.18)	2.32	[5.84, 6.54]	7.00	[7.00, 8.00]
>25 years	6.30 (0.23)	2.41	[5.84, 6.76]	7.00	[7.00, 8.00]
Marital status^d					
Single	5.47 (0.15)	2.58	[5.17, 5.76]	6.00	[6.00, 7.00]
Married	6.41 (0.22)	2.41	[5.97, 6.86]	7.00	[7.00, 8.00]
Divorced	6.50 (0.19)	0.53	[6.05, 6.95]	6.50	[6.00, 7.00]
Living situation^e					
Student residence	4.53 (0.29)	2.52	[3.95, 5.10]	5.00	[4.00, 6.00]
Rented apartment	7.00 (0.21)	2.05	[6.57, 7.43]	8.00	[8.00, 9.00]
With parents	5.44 (0.18)	2.40	[5.08, 5.80]	6.00	[6.00, 7.00]
Living with own family	6.10 (0.30)	2.70	[5.51, 6.68]	7.00	[7.00, 8.00]

Note. Anxiety impact was rated on a scale from 1 to 10. M = mean; SE = standard error; SD = standard deviation; Mdn = median; CI = confidence interval; IQR = interquartile range. Values in brackets represent intervals.

^a $t = 0.85$; $p < .395$. ^b $t = 1.11$; $p = .267$. ^c $F(2, 421) = 16.02$; $p < .001$. ^d $F(2, 421) = 6.22$; $p = .002$. ^e $F(3, 420) = 16.22$; $p < .001$.

Discussions

Anxiety remains one of the most prevalent and clinically heterogeneous mental health conditions worldwide, with major implications for emotional, cognitive, behavioral, and somatic functioning. In the present study, anxiety-related manifestations were common among young people from the Republic of Moldova and showed meaningful variation across socio-demographic categories. Higher perceived anxiety and greater quality-of-life impairment were observed particularly among women, respondents from urban areas, participants aged 20-24 years and over 25 years, married respondents, and those living in rented accommodation. These patterns are broadly consistent with the literature indicating that anxiety is shaped not only by individual vulnerability, but also by social context, life-stage transitions, and differential exposure to environmental stressors (Crețu, 2021; van Baar et al., 2025).

At the neurophysiological level, the symptom profile identified in our study, including palpitations, trembling, breathing difficulties, dizziness, inability to relax, sleep-related complaints, and chronic fatigue, supports the view that anxiety is closely linked to stress-system activation involving the autonomic nervous system and the hypothalamic-pituitary-adrenal axis. These mechanisms help explain why anxiety often presents not as an isolated psychological complaint, but as a multisystem condition with cardiovascular, respiratory, gastrointestinal, and

neuroendocrine correlates (Krystal et al., 2019; Peng et al., 2024; Zvolensky et al., 2015). The association between anxiety and somatic disease is therefore clinically relevant, especially in young adults who may first present in primary care or general medical settings with nonspecific bodily symptoms rather than explicit emotional complaints (Fish, 2020; Kandola et al., 2018; Krueger-Burg et al., 2017).

One of the most important findings of the present study concerns the high burden of sleep problems, excessive thoughts, concentration difficulties, and fatigue. These observations reinforce prior evidence that sleep disturbance is not simply a secondary consequence of anxiety, but may also function as a precipitating and perpetuating factor in the maintenance of anxious symptomatology (Baglioni et al., 2016; Krystal et al., 2019). Likewise, the cognitive manifestations identified in our sample, such as persistent worry, intrusive thinking, fear of adverse outcomes, and diminished concentration, are compatible with cognitive models of anxiety which propose that maladaptive threat appraisal and anticipatory processing reduce executive efficiency and impair academic or occupational functioning (Hutchinson, 2017; Iova et al., 2024). These findings are particularly relevant for the age group of 20-24 years, a developmental stage characterized by educational, relational, and professional instability, where anxiety may become both a psychological burden and a barrier to social participation.

Behavioral avoidance and social withdrawal represent an additional mechanism through which anxiety may compromise quality of life. In our sample, anxiety was frequently associated with academic or workplace contexts, decision-making under uncertainty, unfamiliar situations, and social interaction. Such findings suggest that anxiety among young adults is embedded in everyday performance settings and may be amplified by social comparison, fear of evaluation, and pressure to meet external expectations. This interpretation is supported by the literature describing avoidant behavior as both a consequence and a maintenance factor of anxiety, often contributing to reduced support-seeking, worsening distress, and restricted developmental opportunities (Fish, 2020).

The somatic and psychosomatic dimensions of anxiety also deserve particular attention. Our data showed frequent gastrointestinal complaints, eating-behavior changes, muscle tension, globus sensation, and cardiovascular symptoms. These findings are in line with evidence linking anxiety to gastrointestinal dysregulation, inflammatory processes, and altered autonomic responsiveness, while also highlighting the role of the brain-gut axis in the emergence of distress-related bodily symptoms (Martin et al., 2018; Mayer et al., 2015; Mayer et al., 2023; Morais et al., 2021; Shah et al., 2014; Takeoka et al., 2017; Wu et al., 2022). The concurrent observation of dermatological and other stress-sensitive somatic complaints further supports the notion that anxiety has immune and autonomic consequences extending beyond strictly psychiatric boundaries (Gordon-Elliott & Muskin, 2013; Klimov et al., 2018). From a practical perspective, these results underline the importance of interdisciplinary assessment, especially in patients who initially seek help for physical complaints rather than for anxiety itself.

The present results also raise important diagnostic and public health considerations. Anxiety was more frequently reported by women and was more strongly expressed among urban respondents, findings that may reflect differences in social roles, stress exposure, help-seeking behavior, and health-service accessibility. Previous research has similarly shown that anxiety and related mental health symptoms are unevenly distributed across socio-economic and demographic groups, with women and vulnerable urban populations often reporting higher symptom burdens (Gordon-Elliott & Muskin, 2013; van Baar et al., 2025). In this context, targeted screening in educational institutions, primary care, and occupational settings may facilitate earlier recognition of clinically relevant anxiety, especially where symptoms are masked by somatic complaints or normalized as part of everyday stress. This is particularly important because delayed detection may prolong symptom chronicity and impair quality of life (Fish, 2020; Mbiydenyuy & Qulu, 2024).

Although this study was not designed to test biological mechanisms directly, the observed pattern of symptoms is compatible with broader integrative models of anxiety etiology. These models describe anxiety as the product of interactions among neurobiological regulation, cognitive vulnerability, environmental adversity, and individual susceptibility. The literature highlights the contribution of amygdala-centered threat circuits, inhibitory GABAergic signaling, HPA-axis dysregulation, gene-environment interaction, and microbiota-gut-brain communication to the development and persistence of anxiety symptoms (McKeown et al., 2021; Ministerul Sănătății Republicii Moldova, 2009; Mourtzi et al., 2021; Nechita et al., 2018; Pedersen et al., 2014; Sah et al., 2003; Schiele & Domschke, 2018; Dinan & Cryan, 2017a, 2017b; Morais et al., 2021). In parallel, complementary lines of research have proposed a possible role for vitamin D, inflammatory regulation, and stress-related epigenetic processes in shaping vulnerability and resilience (Martin et al., 2018; Renteria et al., 2024; Schiele & Domschke, 2018).

The COVID-19 period further demonstrated how rapidly external stressors can intensify anxiety and related psychological burden. The broader literature has shown marked increases in anxiety, depression, uncertainty, and perceived distress during the pandemic, reflecting the combined effects of isolation, disruption, and socio-economic instability (Castaldelli-Maia et al., 2021; Chen et al., 2023; Chihai, 2020; McKeown et al., 2021; Salari et al., 2020; Stănculescu, 2022). In this sense, the present findings should be interpreted not only as an individual-level profile of symptom distribution, but also as evidence supporting the need to integrate youth mental health more firmly into public health planning in middle-income settings such as the Republic of Moldova. The relevance of contextual and developmental risk factors is also consistent with broader work on adolescent vulnerability, including evidence regarding family difficulties, school problems, victimization, substance use, and neighborhood influences as factors shaping later psychosocial risk trajectories (Ciurbea et al., 2025).

Several limitations should be acknowledged. The cross-sectional design does not allow causal inference, and the use of a self-administered questionnaire may have introduced reporting bias, recall bias, and participation bias. In addition, some subgroups were relatively small, which may limit the precision of subgroup comparisons. Nevertheless, the study provides valuable descriptive evidence regarding the psychosocial and sociodemographic distribution of anxiety-related manifestations among young people in Moldova. Its strengths include the multidimensional assessment of anxiety-related symptoms, the inclusion of both online and offline respondents, and the attention given to perceived quality of life, support, and behavioral correlates. Overall, the findings support the need for context-sensitive prevention, earlier screening, and interdisciplinary intervention strategies tailored to high-risk young populations.

Conclusions

The study of anxiety has become increasingly prominent across various contemporary scientific disciplines, including medicine, physiology, philosophy, sociology, psychiatry, and psychology. This multidisciplinary interest aims to elucidate the underlying causes of anxiety and to develop effective strategies for its prevention and treatment. Early identification and intervention are essential; as timely management of anxiety can promote optimal adult functioning. Conversely, untreated anxiety tends to worsen over time and may lead to the development of comorbid depression. Anxiety exerts a substantial impact on physical health, as confirmed both by existing literature and by the findings of the present study. It contributes to the onset and exacerbation of various medical conditions, such as cardiovascular diseases, gastrointestinal disturbances, sleep disorders, and dermatological issues, all of which negatively affect individuals' quality of life. The pathophysiological mechanisms underlying anxiety are multifactorial and include endogenous factors such as dysfunctions in the amygdala's inhibitory circuitry, hyperactivation of the hypothalamic-pituitary-adrenal (HPA) axis, gut-brain-microbiota axis

dysregulation, and genetic and epigenetic influences, as well as exogenous factors, including environmental conditions and exposure to stress or trauma.

The present study highlights the high prevalence of somatic symptoms among individuals experiencing anxiety. Gastrointestinal issues were the most commonly reported (50.90%), followed by Globus sensation (30%), muscle tension (25.50%), inability to relax (24.76%), palpitations (17.14%), and changes in eating behavior, alongside frequent complaints of chronic fatigue. Demographic analysis revealed a higher incidence of anxiety symptoms among women living in urban areas (22.63%) compared to those in rural settings (17.97%). Similarly, urban men reported greater anxiety prevalence (20.94%) than their rural counterparts (10.47%). These findings suggest a lower vulnerability to anxiety among rural populations of both sexes, in contrast to their urban counterparts.

Competing interests

The authors declare no competing interests.

Ethics Committee Approval

The psychosocial determinants included in the questionnaire were reviewed and approved by the Department of Mental Health, Medical Psychology, and Psychotherapy of Nicolae Testemițanu State University of Medicine and Pharmacy, at its meeting held on 23 January 2025 (Minutes No. 1).

Consent to participate

All participants provided informed consent prior to enrolment, and data were collected anonymously and processed confidentially.

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