Chapter 6
Anxiety

Caitlin A. Kieltyka and Kimberly D. Nordstrom

Introduction

Anxiety is defined as the psychological and physiological manifestations of excessive worry. While anxiety is a normal reaction that all humans experience, it can become problematic if the anxiety overcomes one's ability to function. Generalized Anxiety Disorder is characterized by excessive worry more days than not for a period of at least 6 months. A Panic Attack is characterized by an abrupt surge in intense fear or discomfort that usually peaks within minutes and includes a host of physiological and psychological symptoms such as palpitations, diaphoresis, chest pain, a fear of losing control and/or a fear of dying. A Panic Attack can be a solitary presenting symptom or can be part of another psychiatric illness such as Panic Disorder, Generalized Anxiety Disorder, or Major Depressive Disorder.

C.A. Kieltyka, M.D. (✉)
Department of Psychiatry, School of Medicine, University of Colorado-Denver, Denver, CO 80045, USA
e-mail: Caitlin.Kieltyka.MD@gmail.com

K.D. Nordstrom, M.D., J.D.
Department of Human Services, Office of Behavioral Health, Denver, CO 80236, USA

American Association for Emergency Psychiatry, Parker, CO 80134, USA

K.D. Nordstrom, M.P. Wilson (eds.),
Quick Guide to Psychiatric Emergencies,
https://doi.org/10.1007/978-3-319-58260-3_6,

Signs/Symptoms

The Diagnostic Statistical Manual-5 of the American Psychiatric Association lists the following sign and symptoms:

- **Generalized Anxiety Disorder**
  - Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities
  - The individual finds it difficult to control the worry
  - The anxiety and worry are associated with three (or more) of the following symptoms
    - Restlessness or feeling keyed up or on edge
    - Being easily fatigued
    - Difficulty concentrating
    - Irritability
    - Muscle tension
    - Sleep disturbance
- **Panic Attack/Panic Disorder**
  - Panic Attack
    - Abrupt surge of anxiety with at least four of the following symptoms
      - Palpitations
      - Diaphoresis
      - Trembling or shaking
      - Feeling short of breath
      - Sensation of choking
      - Chest pain or discomfort
      - Nausea or abdominal distress
      - Feeling dizzy or light-headed
      - Chills or heat sensations
      - Paresthesia (numbness or tingling)
      - Derealization (feelings of unreality) or depersonalization (not feeling like oneself)
      - Fear of losing control
      - Fear of dying

  - Panic Disorder
    - Requires recurrent panic attacks along with at least one of the following lasting for at least 1 month following a panic attack
      - Persistent concern or fear of additional panic attacks or their consequences
      - A significant change in behavior related to the attacks, such as avoiding places or actions such as exercise

Differential

The differential is large. A broad risk of categories and representative samples are used here.

- Psychiatric
  - Social Anxiety Disorder (anticipatory anxiety focused on upcoming social situations)
  - Obsessive-Compulsive Disorder (intrusive and unwanted thoughts, urges or images as opposed to excessive worry about future events)
  - Posttraumatic Stress Disorder (where symptoms that occur following a trauma [E.g. nightmares, flashbacks, re-experiencing] are the primary symptom and anxiety only occurs in the context of this disorder)
  - Adjustment Disorder (anxiety occurs in response to a stressor within 3 months of the onset of that stressor and does not persist more than 6 months after the termination of the stressor or its consequences)
  - Depressive Disorders, Bipolar Disorders, Psychotic Disorders (where mood or psychotic symptoms are the primary symptom and anxiety only occurs in the context of those disorders)
- Non-psychiatric
  - Substance/medication induced (psychostimulants, levothyroxine, albuterol, steroids, caffeine, illicit stimulants, marijuana)
  - Endocrine: pheochromocytoma, hyperthyroidism, thyrotoxicosis

  - Cardiac: arrhythmias, angina, myocardial infarction
  - Pulmonary: pulmonary embolism, COPD, asthma
  - Neurologic: seizure

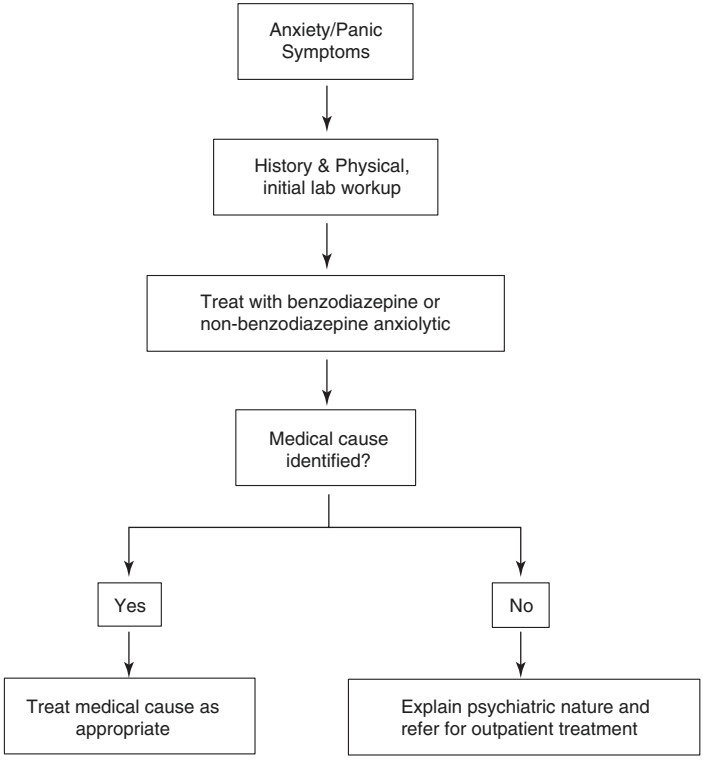
Initial Workup

- HPI:
  - Actual symptoms
  - Precipitating or exacerbating events
  - Duration
  - Timing
  - Severity
  - Be sure to utilize collateral sources of information (family members, friends) if available
  - Be sure to not dismiss physical complaints as "just anxiety," as the patient may have a serious medical condition that is making them anxious
- Suicide Risk (Suicide Risk Assessment, see Chap. 4)
- Substance use (including caffeine)
- Current medication list, as well as supplements
- Past psychiatric and medical history
- Family psychiatric and medical history
- Physical Exam:
  - Full system exam including Mental Status Exam
  - Review vital signs
- Laboratory evaluation should be directed based on history, physical exam, vital signs and differential diagnosis. Common studies to narrow the differential include:
  - TSH
  - Urine toxicology
  - EKG
  - EEG (rarely used in the ED setting)

Treatment

- Initial treatment should focus on reassuring and calming the patient, though this will likely not prevent recurrence and return to the ED
  - Can use a benzodiazepine such as lorazepam or diazepam
  - If concerned about substance use, could use a non-benzodiazepine anxiolytic such as diphenhydramine, hydroxyzine, or propranolol
- Explanation of the psychiatric etiology of the symptoms
  - Try something like "your symptoms are a physical manifestation of psychological anxiety and stress" and put into context of patient's current psychosocial stressors
  - Try to avoid using phrases that are akin to "it's all in your head" as this could be experienced as disparaging
- Secondary treatment could include teaching the patient relaxation techniques. A quick an easy technique such as diaphragmatic breathing could be taught. (See Tool 2 at the end of this chapter)
- Explore the patient's sleep hygiene. A pattern of disrupted sleep can be related to an increase in daytime anxiety. Elements of sleep hygiene include:
  - Setting regular sleep and wake times
  - No caffeine in the hours before bed
  - No vigorous exercise in the hours before bed (stimulates body)
  - Relaxation activities prior to bed: warm shower, reading, etc.
- Referral for psychiatric outpatient treatment and/or therapy to direct patient toward definitive treatment and thus decrease recurrence and return to the ED

Tool



Tool #2

DEEP BREATHING MADE SIMPLE:

Ask the patient to show how he or she breathes when trying to relax. In most cases, the breathing will be fast and you will see the shoulders rise. Point this out to the patient. Now place your hand on your abdomen (showing a patient how to correctly breathe goes a long way). Do 2 or 3 slow, deep, diaphragmatic breaths. Point out that your hand is moving out and in. Have the patient practice this a few times with you (make sure the patient places a hand on his or her abdomen). Point out that the hand is correctly moving out and in and the shoulders are not moving. That's it. You're done.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
2. Buccelletti F, Ojetti V, Merra G, Carrocia A, Marsiliani D, Mangiola F, Calabò G, Iacomini P, Zuccalà G, Franceschi F. Recurrent use of the emergency department in patients with anxiety disorder. Eur Rev Med Pharmacol Sci. 2013;17:100–6.