31 Communication with Patients with Anxiety Disorders

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> The fear of a tightrope walker: whose net he might fall into.
>
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Abstract: This chapter discusses the communication challenges that arise when dealing with patients with anxiety disorders. The importance of this topic for everyday clinical practice is demonstrated by the frequency of the disorder (§ 31.1). It is helpful to understand that even apparently unfounded pathological anxiety is fuelled by "deeper" and biographically understandable fears. This is the only way to fulfil the patient's need to have their anxious feelings taken seriously. Awareness of one's own feelings also plays an important role (§ 31.2). We use practical examples to show ways of not acting against the fear (and therefore inevitably against the patient), but of finding a solution to the situation together with the patient that accepts the anxiety (§ 31.3).

31.1 Epidemiology of anxiety disorders

Anxiety disorders are the most common group of all mental disorders. A study in the German population (Jacobi et al. 2014) found that within one year, a total of 16% temporarily or permanently fulfilled the criteria for an anxiety disorder. Every clinically active doctor will therefore encounter patients with an anxiety disorder in their daily work. The overall prevalence of anxiety disorders among patients in a general practice or a clinical emergency department is approximately 19.5% (Kroenke et al. 2007)

Anxiety patients often initially present to the doctor with physical symptoms. The physical symptoms of panic disorder, which are experienced as very threatening, often lead patients to general or cardiological emergency departments. Good communication between doctor and patient is then required to correctly categorise the symptoms, make and communicate the correct diagnosis convincingly, and motivate the patient to seek appropriate treatment. A Canadian study showed that the number of incorrect or missing diagnoses of anxiety disorders is alarmingly high (between 71% for generalised anxiety disorder and 98% for social phobia) (Vermani et al. 2011)

However, anxiety disorders can also disrupt everyday treatment processes outside the emergency department, especially if the doctor has not recognised and addressed the comorbid anxiety disorder. For example, a patient with panic disorder who has been temporarily prescribed a benzodiazepine due to sleep disorders may also use it to reduce anxiety and develop an addiction. A patient with agoraphobia does not attend an urgently recommended specialist appointment because she is afraid of travelling unknown distances by car. A patient with a generalised anxiety disorder cannot be reassured before a planned operation, even though he has been sensitively informed. A patient with claustrophobia refuses to have the necessary MRI because the confined space makes her panic. A patient with a phobia of syringes does not address this, but faints when blood is taken.

As a doctor, how can you communicate in such a way that you recognise an anxiety disorder as far as possible, and find good solutions with the patient in difficult situations?

31.2 Understanding anxiety disorders

Box 31.1 Patient example 1.1

As a ward physician on a normal internal medicine ward, you come into a patient's room to explain a gastroscopy. You notice that the patient is paying very close attention, listening carefully to the various details and asking repeatedly about the complications mentioned. In addition, he repeatedly indicates that he is not at all confident, as "anything could happen", and asks about alternatives to treatment and whether "wait and see" would also work. When you ask at the end of the consultation whether there are any unanswered questions, the patient mentions that he is afraid that you will "accidentally catch the wrong tube" during the gastroscopy and that he would then "not be able to breathe". You reassure him that this would not happen with an experienced internist and that even if it did, it would be noticed and corrected immediately. The patient hears this but cannot calm down. He then wants to know what would actually happen if the examiner were to fall ill during the gastroscopy and have a heart attack, for example - who would look after him then? Already slightly annoyed, you assure that such incidents might not be impossible but are very unrealistic, that the gastroscopy is not dangerous in itself and that there are enough staff present to prevent anything serious from happening (to him). You feel increasingly annoyed because you have the feeling that the patient does not want to trust you, and because this conversation is already taking longer than planned. At the end of the consultation, the patient refuses to sign because "with so many risks, it's more of a suicide mission than anything else". He would also like to speak to the senior consultant in charge, who perhaps has "a bit more experience" and could "allay his fears".

Both you as the ward physician and the patient are likely to emerge from this situation (Box 31.1) unsatisfied and misunderstood. In order to gain access to the patient, the first challenge for you is to understand the patient, their situation and their fears. Only then will you be able to find a common level of dialogue and subsequently convey professional information. This case study will therefore be used to explain the general mechanisms, characteristics and differentiation of anxiety and anxiety disorders.

31.2.1 “Normal” or realistic fear and anxiety disorder

First of all, it is important to distinguish between the general term 'fear' and 'pathological fear' or pathological anxiety. Fear is one of the basic feelings of every human being and has a biologically meaningful function in recognizing potential dangers (for example, a truck driving towards us) and – if necessary – in initiating appropriate countermeasures (jumping off the road). This must be distinguished from pathological fear, which is characterized by exaggerated, unrealistic thoughts or reactions, even if it starts from a natural basis (see e.g. Bandelow et al. 2021). You can also find both in the case study above: The basic fear of relinquishing control (anesthesia) or fear of (postoperative) bleeding are understandable and realistic. On the other hand, the fears of "accidentally" suffocating due to clumsiness on the part of the practitioner or of being "forgotten" if the practitioner himself becomes ill can certainly be described as less understandable and unrealistic. Nevertheless, pathological fears or anxiety arise from a cause, and you will be more understanding with your patients if you have understood this principle.

31.2.2 Pathological anxiety: Explanatory models

In psychotherapy, there are two central explanatory models for the development of pathological anxiety, the psychodynamic model and the behavioural model, which will be briefly discussed here.

The *psychodynamic model* of the development of anxiety is based on the idea that there are ongoing intrapsychic conflicts within each individual that are shaped by their life history. An example of such a conflict is the desire for parental care on the one hand and the desire for independence on the other. This is well resolved if the child feels protected by the parents, but also experiences that it is sometimes allowed to assert its own will and distance itself from the parents. The conflict remains unresolved if it is not possible to try out both sides in a balanced way, e.g. because the parents neglect or beat the child, or because they are overprotective or overly restrictive. The temporary solution is then to either only take the side of being cared for or only the side of autonomy, e.g. the patient becomes extremely dependent on others ("I don't trust myself to do anything, I need others and I’m afraid of being abandoned") or extremely autonomous ("I do everything myself

because I fear being restricted or disappointed"). Unconsciously, however, both the longing for the unlived side and the fear of it remain. This works relatively well until the unlived side of the conflict is also addressed, usually in a stressful situation. For example, a very dependent person may feel the need to express their own wishes to a doctor or make their own decisions, but this need awakens the fantasy of being rejected or poorly cared for. On the other hand, a physical illness can lead to a longing to be supported and comforted by others, which the autonomous person may find difficult to express for fear of losing control.

In the example above, the patient only feels that the situation is causing him persistent and increasing discomfort. The unconscious reason for this is that he must give up control and trust others in an uncertain situation. Although this is a difficult step for any patient, it is a particularly threatening situation for the patient described above because of his biography (see below). He consciously experiences this as the feeling that the anesthetic is not really safe and that the doctor is unable to reassure him. However, additional factual information does not change his basic feeling much. This in turn makes the doctor angry at some point, who perceives this as an attack on her competence.

The *behavioural theory model* sees the cause of the symptoms as the conditioning of symptoms, i.e. the association of anxiety with certain situational conditions, and dysfunctional, i.e. exaggerated or unrealistic, anxiety cognitions. These were also acquired over the course of life. Childhood experiences of violence can lead to a loss of control associated with physiological fear responses. They can also shape the belief that “something dangerous will always happen if I am not careful enough”. An over-anxious upbringing can lead to a habitual over-emphasis on danger. It also makes it difficult to develop a belief in self-efficacy, the basic confidence that I can successfully influence the course of events myself. Common features of an anxiety disorder include cognitive errors such as catastrophizing (i.e. thinking only the worst of all possible outcomes without considering the probabilities), an overestimation of physiological body processes triggered by anxiety as dangerous, and a strong tendency to avoid anxiety-provoking situations instead of actively coping with problems.

Box 31.2 Patient example 1.2

When asked, the patient hesitantly recounts that two years ago, after his daughter's tonsillectomy, a post-operative hemorrhage was not noticed until late in the recovery room. He could only watch through the window as the doctors attended to the child. He felt extremely panicked and helpless. Since then, his trust in doctors has been shaken, although he is not sure if anything was done wrong at the time.
The biographical history revealed that the patient's father had left the family at an early age. The patient was therefore the main carer for the mother, who was very anxious and overprotective. Even as a child, he had looked after her a lot and taken responsibility for her. To this day, he endeavours to do everything right and finds it difficult to leave things to others. He had always been a rather cautious person, but it was only since his daughter's operation that he began to avoid doctors and hospitals. It was only at the insistence of his GP that he agreed to the current examination.

By addressing only the current external conditions and not the emotional basis of the anxiety, both the patient and the physician failed to alleviate their fears. Regardless of the explanatory model, it is important to understand that in the case of pathological anxiety, the currently perceived (expressed or unexpressed) anxiety does not only relate to the current situation but is a trigger for a more deeply rooted fear, which in turn has been shaped by previous experiences. This often means that logical argumentation or the citation of medical expertise can only reassure the patient to a limited extent (or not at all). The patient desires nothing more than to ease his fears but is "wired" in such a way that, no matter how irrational they may seem, he cannot overcome them. At the same time, he is ashamed of having such fears. He then either appears to adapt, but goes into avoidance - for example, by repeatedly failing to turn up for the agreed examination. Or he tries to cope with the shame by accusing the other person of not being caring enough. Sooner or later, both lead to a serious disruption in the doctor-patient relationship.

You will not always have time for a complete biographical history. In acute situations in particular, you are closer to a solution if you accept in principle that the patient's fear is justified. However, a former doctoral student of ours, who now works as a surgeon, described it like this: "During the first contact, I take a little more time to listen and am

pleased when I learn more about the life stories. After that, every brief contact is more cordial - and the patients love me!"

31.2.3 Anxious countertransference

Another challenge that arises when dealing with anxiety patients is that of your countertransference. Countertransference is the feeling that is triggered in you by your interaction with the other person. This may be a feeling that arises as a complementary reaction to the patient's behaviour, or it may be a feeling that the patient himself feels and "passes on" to you (“concordant countertransference”). You will probably initially react to the patient's anxiety with care. This is a good thing as long as it does not lead to too much identification with the patient (problematic would be: "I must and will save this patient"). If feeling or acting in a caring way turns out to be not very effective, you will also begin to feel helpless, and caring can quickly turn into anger (because the patient "disregards" your expertise and efforts). Another common possibility is that you, just as the patient, begin to feel insecure or anxious (e.g. the interaction makes you feel overwhelmed and unsure in your role as doctor, and you wish that someone else was responsible for this patient). In the first case, a typical reaction would be to categorise the patient as a 'difficult patient' and get upset with him. If the patient senses your anger and the rejection they fear, the doctor-patient relationship may be permanently damaged. In the case of "carried-over" anxiety, things can become even more complex because your personal approach to dealing with the feeling of anxiety becomes relevant. Nobody likes to recognise their own fears and insecurities - so it is often easier to ward off fear than to deal with it, especially in the stressful daily work as a doctor. As a consequence of wanting to "make the fear go away", you may end up avoiding or fighting the factor that triggers the fear (i.e. the patient), e.g. by not going into their room as often, not addressing their fears any further or, in the worst case, "sedating" them with tranquillisers.

Therefore, try to honestly perceive the feelings that the patient triggers in you. Realise that in every communication, fear on the one side will trigger feelings on the other side (e.g. concern, helplessness, feelings of guilt, anger, fear or insecurity). This is normal and not a problem if you take a break between your feelings and your actions and consciously decide whether you want to act on your feelings or not. If you have strong feelings of countertransference, it is better not to let them guide

you, but to understand them (ideally by talking to others), to "reveal" them and let them fade away.

31.2.4 Diagnosis

The diagnosis of an anxiety disorder and the further specification of which anxiety disorder is present is made on the basis of the patient's medical history and, if necessary, differential diagnostic (somatic) examinations. A detailed description of the various clinical pictures would go beyond the scope of this book, so we refer you to the relevant specialist literature from the fields of psychosomatic medicine and psychiatry as well as to the S3 guideline "Treatment of Anxiety Disorders" (Bandelow et al. 2021). A brief summary of the most important disorders is given in Box 31.3.

Box 31.3	Overview of important anxiety disorders, modified/abbreviated according to ICD10

Panic disorder
Recurrent severe panic attacks with sudden palpitations, chest pain, feelings of suffocation, dizziness and feelings of alienation. There is often a secondary fear of dying, of losing control or of going insane.

Generalised anxiety disorder
Generalised and persistent anxiety and worry that is not limited to specific environmental conditions ("free-floating"). The symptoms are variable; complaints such as constant nervousness, tremor, muscle tension, sweating, light-headedness, palpitations, dizziness or upper abdominal discomfort are part of this picture. Often the fear is expressed that the patient themselves or a relative could soon fall ill or have an accident.

Social phobia
Fear of scrutiny from other people, leading to avoidance of social situations. More extensive social phobias are usually associated with low self-esteem and fear of criticism. They can manifest themselves in symptoms such as blushing, trembling hands, nausea or the urge to urinate. Sometimes the person concerned believes that one of these secondary manifestations of anxiety is the primary problem. The symptoms can escalate into panic attacks.

Specific phobia
Phobias that are limited to narrowly defined situations such as proximity to certain animals, heights, darkness, flying, enclosed spaces, urinating in public toilets, eating certain foods, visiting the dentist or the sight of blood or injuries. Although the triggering situation is strictly limited, it can cause panic states similar to agoraphobia or social phobia.

31.2.5 General communicative aspects

The following basic principles for communicating with very anxious patients result from what has been explained so far:

- As with all situations in which emotions play a role, the principle of empathic listening applies: Name the feeling that you perceive in the patient *("The examination is causing you anxiety." "You seem very insecure to me right now."*). Then give the patient time to respond. They will respond by telling you more about themselves. Encourage them to continue talking by responding again with understanding listening (naming the feeling expressed).
- Behind aggressive behaviour often lies fear. Empathic listening is particularly helpful in this situation.
- The technique of empathic listening also means that you clearly state the patient's view you perceive without contradicting it in the first step (e.g. “You believe that this examination is not safe.”). The fact that you name and understand the patient's position does not mean that you agree with it, but if you take the patient's side first, they will be more willing to accept your perspective later.
- Empathic listening helps the patient to become clearer about their own feelings and strengthens the doctor-patient relationship. This is the most important basis for successful communication.
- The second step is to ask: What is the patient most afraid of? What do they fear might happen? What would make them feel safer?
- Only in the third step is it appropriate to provide the patient with technical information.
- The desired solution is not that the fear disappears. The desired solution is that the patient and you can take the necessary and

important steps in diagnosis and treatment, even if the patient is afraid. Recognise the fear and work together with the patient to explore options.

- Be aware of your feelings of countertransference. If these are strong, lean back in your mind and slow down the pace of the conversation. Convey that you can bear the patient's fears, even if there is no simple solution yet.

Further steps are necessary to correctly diagnose and manage anxiety disorders:

- Ask the patient whether they are familiar with fears from other situations.
- Screening questions are:
  - *Do you sometimes have sudden episodes of strong physical arousal or anxiety?*
  - *Are there things or situations in everyday life that you avoid for fear of becoming anxious (e.g. crowds, department stores, travelling by bus)?*
  - *Are you constantly worrying about all sorts of things?*
  - *Is one of your worst fears being embarrassed or being judged negatively in a group?*
  - *Are there any situations that particularly frighten you (e.g. animals, heights, confined spaces)?*
- If the patient answers a question in the affirmative, explore the potential anxiety disorder further. Remember that an anxiety disorder rarely comes alone: there are often several comorbid anxiety disorders or comorbid depression at the same time.
- Be aware of vegetative physical symptoms that may indicate an anxiety disorder.
- If a patient says that they have no anxiety, but only unexplained physical symptoms, accept this for the time being. Some patients have learnt from childhood not to show anxiety and can only perceive the physical phenomena.
- The patient is already ashamed of their "unnecessary" anxiety. Avoid further shaming. Normalise their feelings by explaining that many people have "unrealistic" fears.
- It is helpful to offer a patient with an anxiety disorder a psychophysiological explanatory model. An example might look like the one described in Box 31.4:

Box 31.4 Psychophysiological explanatory model

"Biology has equipped us with a well-functioning fear system so that we can fight or flee in the face of danger. This kicks in at any form of perceived threat. It increases the heartbeat, breathing and muscle tension so that a lot of oxygen reaches the muscles and we can run fast. The faster breathing causes a lot of CO_2 to be exhaled, which can lead to a feeling of breathlessness, dizziness and tingling. However, there is always more than enough oxygen in the body. The symptoms you have described can all be explained by this anxiety reaction. This is harmless, you cannot die of anxiety. If someone has a sensitive anxiety system, this anxiety reaction occurs more quickly. Then even situations that are not dangerous in themselves can trigger anxiety. An anxiety system can be genetically more sensitive or become more sensitive as a result of negative experiences in childhood or later in life. The fear response occurs very quickly so that we can react quickly. This means that it is often difficult for us to influence the anxiety in the situation. However, it is possible to reduce sensitivity in the long term, for example through psychotherapy or medication."

- Treatment options for anxiety disorders are well described in treatment guidelines. Psychotherapy or pharmacotherapy are recommended.
- If you recommend psychotherapy, also explain to the patient how to proceed to obtain an initial consultation and encourage the patient to be persistent in their pursuing of psychotherapy. If possible, arrange an appointment with you in four weeks' time to discuss whether they have been successful.
- It is very tempting to "solve the problem" by administering a benzodiazepine. By doing so, you will have relieved yourself, but you may be doing the patient a disservice. The administration of a benzodiazepine is usually unnecessary, even in acute anxiety attacks, and conveys to the patient that only a drug will help; in the long term, there is a high risk of developing (iatrogenic) psychological and physical dependence. Benzodiazepines should therefore only be given in exceptional circumstances, e.g. in patients with severe heart disease or suicidal behaviour. Benzodiazepines are acceptable when the anxiety situation is specific and unique, e.g. before an operation or invasive procedure or for an MRI scan.

31.3 Practical examples

31.3.1 The anxious patient / the patient with generalised anxiety disorder

Let us return to the case study in Box 31.1/2. This could happen in the same or a similar way in any internal medicine ward in a hospital. The patient clearly shows you that he is afraid, both for understandable reasons (= realistic fear of possible complications of a gastroscopy) and for unrealistic complications (choking due to incorrect use of the trachea, fear of the physician having a heart attack during the gastroscopy). He expects you, in your role as a doctor, to allay this fear. The patient does not recognise the difference between realistic and pathological fear and considers both to be equally important.

Because of the mixed picture of “normal” fear and pathological fear that presents itself, you can only fail the patient's task ("take away my fear") if you try to solve this purely through logical thinking and specialised medical knowledge. You cannot resolve the pathological fears in this situation. The most adequate way to alleviate anxiety here is for the patient to feel that they are in good hands with you. You do not achieve this verbally and cognitively through factual information, but mainly through an empathetic and understanding style of dialogue. Therefore, whenever you sense that emotions are taking center stage, switch from explaining to listening with empathy until you have really grasped the patient's emotions (see below). If you succeed in doing this, the patient will feel taken seriously and accepted and may feel some of the security that they lack (intrinsically, i.e. from within themself) due to the (stressful) situation. Then ask for permission to give them further explanations. If the patient persists in their fear, show understanding again and ask whether there is a way for them, with the information they now have, to give their consent to take the necessary steps despite their fear. Ask what could help them to do this. In the best-case scenario, you can build up enough trust so that the patient sees the possibility of overcoming their fears and confiding in you and your colleagues despite their anxiety.

Box 31.5 Patient example 1.3

Doctor: "When you say that anything can happen during a gastroscopy, what do you mean?"
Patient: "Well, you hear so much. For example, that the tube is not inserted into the oesophagus, but into the trachea."
Doctor (doesn't contradict him, but answers understandingly): "You have the idea that the gastroscopy tube could be accidentally pushed into the trachea, and that scares you a lot."
Patient: "Yes, exactly. Then I wouldn't be able to breathe, but because of the medication I'm on, I might not be able to react at all."
Doctor (remains understanding): "You have the feeling that you are putting your life in the hands of the doctors and would no longer be able to protect yourself if something went wrong."
Patient: "Yes, just so! I don't even know if the doctor is really trained to do it properly."
Doctor (stands on the patient's side, asks for his permission for factual information): "Yes, then I can understand that this is a very difficult decision for you. Many patients find it difficult to put themselves in the hands of doctors in this way. I would like to give you a little more information, is that OK with you now?"
Patient: "Yes, that's why we're sitting here!"
Doctor (now does not have to argue against the patient but has his invitation to explain): "Nowadays, there is a camera at the tip of the tube, which is switched on right from the start. So, the doctor can see exactly where he is inserting the tube. This means that the tube cannot get into the trachea, which is very easy to distinguish from the oesophagus from the outside and inside. Any doctor can see that. Dr X is a very experienced doctor who performs all our gastroscopies."
Patient: "Yes, but it could still happen by mistake."
Doctor (doesn't get into an argument and doesn't devalue the fear): "I'm sure that won't happen, but I hear that you're very scared. Is there anything that could help you to have the examination despite this fear?"
Patient: "I find it difficult that you are informing me here, but I haven't even seen Dr X yet. If I'm pushed into the examination room tomorrow, it will be too late for me."
Doctor: "Would you like to get to know Dr X. first so that you can have more confidence?"
Patient: "Yes."
Doctor: "Good, but unfortunately that's not possible right now because he's at the examinations. The law states that the medical information must be provided to the patient 24 hours before the gastroscopy. So you

would have to sign now so that we can do it tomorrow morning. We could do this together now and I can still organise for Dr X to come and see you again this evening. However, if you want to wait until this evening to sign, we wouldn't be able to carry out the examination tomorrow and we would have to make a new appointment. What would you prefer?" (Gives the patient a choice and therefore a sense of control).
Patient: "Well, I've been here before, I can't stand it again! Can I withdraw my signature tonight if I'm not convinced?"
Doctor: "You can do that at any time anyway. Of course, we would prefer it if we could dispel your doubts so that you feel that you are in good hands with us despite your fears. You are welcome to ask Dr X any questions you still have this evening, but after a long day he will not be able to repeat the whole consultation. But you are free to decline the examination at any time."
Patient: "Fine, I'll sign now, but I won't have an examination tomorrow if Dr X doesn't come tonight!"
Doctor: "Good, I'll do my best so that we can get through this together well! I'll come and see you again around four o'clock."
Patient: "Yes, I would like that."

The doctor did not allow herself to be tempted to respond immediately with counter-arguments, but instead listened attentively and empathetically and recognised the emotional side of the problem. She also respected the patient's autonomy and assured them of her care by announcing further contacts. This helped the patient to gain trust.

At the second contact, if the doctor has a few minutes and has the courage to do something unusual for her role, she could offer the patient a relaxation exercise to help them calm down (Box 31.6).

Box 31.6 Relaxation exercise for patients in hospital

You can offer patients the following short relaxation exercise - if they are able to engage with it, there is also a good opportunity for patients to continue this on their own responsibility.

Relaxing breathing technique

- Principle: Exhale more slowly and for longer than you inhale
- Aim: Calming of the vegetative nervous system, distraction from circling thoughts by paying attention to breathing
- How to do it: The exercise takes a few minutes and can be done sitting, lying or standing.

- Instructions: Instruct the patient that it is important to exhale slowly and for a long time, i.e. that the exhalation is significantly longer than the inhalation.
- As the patient inhales, raise your hand and count to three and as they exhale, lower your hand and count to five. (CAVE: It is important to ensure that the patient is breathing normally, does not feel obliged and get tense and is not hyperventilating).
- As soon as the patient can do the exercise well, they can be asked to continue at their own pace and count along in their own thoughts. Make sure that the exhalation continues to be longer than the inhalation.
- The patient should practise this breathing technique several times a day in order to remember it when necessary (tension/anxiety, circling thoughts, etc.) and to be able to use it safely.

31.3.2 The patient with panic disorder

Box 31.6 Patient example 2.1

A young female patient (23 years old) presents at the emergency department of a hospital. From the very first contact, you notice the patient's extreme tension, which is reflected, among other things, in her hectic narrative and dramatic choice of words. She had been shopping with her boyfriend in a department store today when she was suddenly overcome by a strange sensation; she suddenly became very hot, then cold again. She started sweating (although it was actually cold in the department store because of the air conditioning). She had difficulty breathing because she had to breathe very fast. She also felt pressure on her chest and felt dizzy. Her heart was beating "up to her neck" as if it was about to "jump out of her chest". She did not show signs of cyanosis, but she was very afraid of fainting or even dying. After all, there was no one in the department store who could have helped her! She then had an ambulance called to bring her here. The physical symptoms have now disappeared, but she still feels a bit unwell. Something similar had happened about 14 days ago and she had already been to the emergency room then.
The further medical history (focusing on clinical emergency diagnoses such as myocardial infarction, pulmonary embolism, etc.), as well as the clinical and laboratory tests performed, revealed normal somatic findings. A glance at the outpatient letter from 14 days ago reveals that the medical findings at that time were inconspicuous as well.

This is a classic example of an anxiety disorder that you may encounter in the emergency department. The patient concludes (quite logically) from the sudden onset of severe symptoms and the associated fear of death that she is suffering from a threatening physical disorder. As a doctor, she expects you to reduce her acute anxiety by using your medical skills to save her from death and then to ensure that a (somatic) diagnosis is made, treatment is initiated, and further attacks are prevented (§ 32).

In most cases, the presence of the doctor alone helps to reduce anxiety quickly ("a saviour is there and doing something"). In this situation, a benzodiazepine is often given prematurely. This seems more convenient for both sides, certainly for the doctor, than staying in contact and waiting for the anxiety to subside naturally. At the same time, however, the patient learns that the attack is actually dangerous and can only be treated with medication. Her anxiety in situations where immediate medical help is not available will therefore continue to increase. In addition, she will demand benzodiazepines the next time she has an attack, preferably as a prophylactic measure. However, these have a high dependency potential. They may then contribute, completely unnecessarily, to iatrogenic drug dependency.

Of course, your first task is to rule out any acutely threatening physical differential diagnoses (Bandelow et al. 2021). For legal reasons alone, you will hardly be able to avoid this in the emergency department. However, if these tests have already been carried out, there are no other signs of a new illness, and the symptoms are typical of a panic attack, they do not need to be repeated unnecessarily. In the case of (all) anxiety disorders, superfluous somatic diagnostic procedures lead to a consolidation of the fear of a physical illness ("the doctor also actually believes that something is physically wrong with me"), a delay in adequate therapy and unnecessary costs.

Let's return to our example. From your medical understanding, you expect that informing the patient that all the findings are normal and therefore everything is fine will reassure her. This may even be the case in the short term. However, you have not resolved the blatant contradiction between the patient's extremely frightening experience and your statement that there is nothing to worry about. (Imagine you distinctly feel a bone in your throat after eating, every time you take a breath, and feel increasingly afraid of choking on it, but your friend, whom you ask to look, says she sees nothing. That probably wouldn't really satisfy you

either). Reporting the negative findings is therefore only the smaller part of your medical task (§ 31.2.2). Much more important is a comprehensible explanation of how this attack comes about and why this experience is scary, but not dangerous (and not only that it's not dangerous!). To do this, you need to know and ask about other symptoms of panic disorder such as typical vegetative symptoms, anticipatory anxiety and avoidance behaviour. Based on the symptoms, you should then tell the patient your suspected or secured diagnosis and be able to explain at least the basics of what a panic disorder is. Only then will the patient be sufficiently motivated to follow your advice to see their GP or a specialist (specialist in psychosomatic medicine, psychiatry or psychology) for further diagnosis or treatment.

The principles of communication for functional/psychosomatic/somatoform disorders, or in newer terms of bodily distress syndrome or somatic symptom disorder (§ 32) also apply when communicating an anxiety disorder diagnosis. It is important to approach the patient with empathy and seriousness and not to question the existence or importance of symptoms, may they be of somatic or psychological origin. The patient's symptoms are real and impairing; your common goal with the patient is to clarify their origin and treat the disorder. Due to negative previous experiences (e.g. family, friends or other medical contacts), patients often fear that they will automatically be denied credibility or accused of "simulation" because of somatically bland examination results. Your task is to convey that the experience of severe symptoms and the absence of somatic findings are by no means contradictory, but can, in the present example, indicate an anxiety disorder. In this way, you confirm the patient's experience instead of "falsifying" it.

Box 31.7 Patient example 2.2

"I'll summarise the situation again: [recount symptoms, state patient's fears if applicable]. I understand that your first thought was that there was something wrong with your heart. However, the examination results show that there is nothing wrong with your heart. From what I have heard from you so far, the most likely diagnosis would be a so-called panic disorder. This is particularly common in younger patients who, like you, are under a lot of stress from different sources, or whose body simply tends to react quickly. In a nutshell, you could say that with a panic disorder, the anxiety system in our body starts up too quickly. This hap-

pens when the anxiety system has become hypersensitive due to many stresses in life, or under current stress. All the symptoms you mentioned (...) originally serve to enable you to run away or fight quickly in an anxiety situation (it's like running 100 meters untrained). Biologically we are made for this, it is completely harmless, the body can withstand it well, but it feels very threatening. An anxiety disorder does not usually disappear by itself, but it can be treated well. The treatment of choice is psychotherapy or medication, so-called SSRIs. It is important that you discuss this again with your GP. Please make an appointment with him or her as soon as possible."
As a GP, you can already make a diagnosis and discuss the treatment options or arrange further diagnostics if necessary.

Box 31.8 Patient example 2.3

While you are in the doctor's room preparing the patient's outpatient letter, you are called into the patient's room by a nurse. The young woman is talking even more frantically than before, supporting herself with her arms on her legs, shortly afterwards she gets up and walks around the examination room. She begins to breathe faster and faster, interrupted by short bursts of words such as "I can't breathe" "what's going on here" "I'm going to keel over". Suddenly, her legs give way, and you manage to just barely get her onto a chair, where she continues to hyperventilate.

This would be a classic case of an acute panic attack. Possible interventions for an acute panic attack:

- Speak the patient's name out loud:

"Mrs Meier, can you hear me? Please look at me."

- Calm them down and direct their attention away from their body to their surroundings:

"You're having a panic attack. It's scaring you, but it's not dangerous and will pass. We'll wait together until you calm down."
"You are here in xxx, in the clinic for...; you are safe here, nothing will happen to you."

- Give instructions regarding behaviour:

> "Put your feet firmly on the floor, feel the ground under your feet / the chair you are sitting on."
> "Breathe more slowly and not so deeply, breathe with me...in...and out...and in...and out..."

- If necessary, have the patient breathe into a bag. (Caution: Only if the patient signals that she agrees to this, do not force it! Otherwise it can increase the fear of suffocation).

Common "mistakes" to avoid in this situation:

- Don't give tranquilliser to save time (see above).
- Don't become frantic yourself. It can be helpful to check with yourself whether you really believe that a panic attack and hyperventilation are harmless. If not, read about what happens physiologically during a panic attack. Everyone starts breathing normally again at the latest when they pass out. Remember how it feels to inflate an air mattress with your breath or do a self-experiment with three minutes of strong hyperventilation in a quiet hour (you won't die either).
- Don't leave the patient alone - if you don't have time, put the patient with an experienced and calm nurse and come back later.
- Don't consider the problem to be over once the panic attack has subsided - the attack is only a symptom, the disorder remains. It is your job as a doctor to talk to the patient about what is happening so that they receive the right treatment, and the symptoms do not become chronic.

31.4 Further information

Dorothy Stubbe starts her paper ("Alleviating Anxiety ...") (2017) with a quote from Roy T. Bennet: "When we listen with curiosity, we don't listen with the intent to reply. We listen for what's behind the words." It's short and worth reading!

The paper by Charlotte Archer et al. (2021) gives an insight on doubts and chances around diagnosing a patient with an anxiety disorder.

Per Fink's and Marianne Rosendal's book (2015) ("Functional Disorders and Medically Unexplained Symptoms") presents a good orientation on the role of health anxiety in functional disorders and ensuing communication issues.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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