

Anxiety: Panic and Agoraphobia Assessment (Behavioral Health) - CE

ALERT

Panic disorder, with or without agoraphobia, can increase the risk for suicidal ideation in behavioral health patients.¹⁴

Assess a patient's cardiac status when panic disorder symptoms are present; panic disorder may be associated with cardiac disorders.⁴

OVERVIEW

Panic disorder is an anxiety disorder that involves the sudden and recurrent experience of intense fear or intense discomfort, referred to as a panic attack. The patient having a panic attack can experience both physical and cognitive symptoms.¹ Due to the somatic nature of the symptoms, patients with panic disorder seek medical attention more often than the general public.⁶ According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)*, a patient with panic disorder must experience at least four of these thirteen signs or symptoms, and these signs or symptoms must not be related to another condition:¹

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light-headed, or faint
- Chills or heat sensations
- Paresthesia (numbness or tingling sensation)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying

Agoraphobia is a fear or anxiety about two or more of these five situations delineated in the *DSM-5*:¹

- Using public transportation (e.g., automobiles, buses, trains, ships, planes)
- Being in open spaces (e.g., parking lots, marketplaces, bridges)
- Being in enclosed spaces (e.g., shops, theaters, cinemas)
- Standing in line or being in a crowd
- Being outside of the home alone

The fear is related to thoughts that escape will be difficult or help will not be available if panic symptoms or other embarrassing symptoms develop.¹

Although panic disorder and agoraphobia may begin in childhood, the typical age of onset for panic disorder is early adulthood and late adolescence and early adulthood for agoraphobia.¹ Both disorders are more common in female patients.¹

There is evidence that both disorders have a genetic component.⁷ Several studies have also identified cigarette smoking as a risk factor related to panic disorder and agoraphobia.¹⁷

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Patients can experience panic disorder and agoraphobia independent of each other or they can experience both disorders.¹ Patients with panic disorder and agoraphobia experience more severe symptoms and have a greater number of comorbid psychiatric conditions.¹¹

Signs and symptoms of panic disorder can appear as signs and symptoms of cardiac or respiratory disorders, and panic disorder can also increase the risk of comorbid cardiac and respiratory disorders.⁹ Therefore, it is essential that an evaluation of the patient's medical condition be included in any assessment of a patient who presents with physical manifestations consistent with panic disorder.⁹ Patients can also experience panic attacks that do not involve any experience of fear or anxiety. These are referred to as nonfearful panic attacks.¹⁰

It is also important to realize that not all panic attacks happen within the context of a panic disorder.² Panic attacks can happen as isolated events or in the context of another disorder such as posttraumatic stress disorder (PTSD), social anxiety disorder, or some medical conditions, including cardiac conditions or seizure disorders.²

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Establish a rapport with the patient, family, and designated support person that encourages questions. Answer them as they arise.
- Consider the patient's, family's, and designated support person's values and goals in the decision-making process.
- Assist the patient, family, and designated support person with recognizing signs and symptoms of acute exacerbation of the illness.
- Explain the manifestations of the illness and expected progression of symptoms if the patient experiences a relapse. Describe what the family and designated support person are likely to see, hear, and experience (e.g., patient reports of pounding heartbeat, sweating, shortness of breath, chest pain, nausea, dizziness, tingling, feeling unreal or detached, fear of losing control or dying). Advise the patient, family, and designated support person of steps to take if relapse occurs.
- Explain to the patient, family, and designated support person that the main goal is to provide a safe, secure place to receive treatment.
- Explain how the behavioral health unit may be different than other settings. Interaction is promoted between patients and staff, and group meetings are encouraged. To ensure patients' safety, they are checked on frequently throughout the day.
- Educate the family and designated support person regarding the nature of psychiatric illness and expected signs and symptoms (e.g., pounding heartbeat, sweating, shortness of breath, chest pain, nausea, dizziness, feeling unreal or detached, fear of losing control or dying).
- Assist the patient, family, and designated support person with engaging and participating as drivers of the plan of care.
- Explain the importance of following the medication regimen as ordered. The patient should not alter the dose or stop taking the medication even if symptoms have subsided and he or she is feeling better.

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ASSESSMENT

1. Perform hand hygiene.
2. Introduce yourself to the patient, family, and designated support person.
3. Verify the correct patient using two identifiers.
4. Assess the patient's mental status and ability to understand information and participate in decisions. Include the patient as much as possible in all decisions.
5. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.¹²
6. Evaluate the patient's, family's, and designated support person's understanding of the patient's illness.
7. Assess and discuss the patient's goal for treatment.
8. Collaborate with the patient, family, and designated support person to develop a plan of care.
9. Identify the patient's psychiatric advance directives, if available.
10. Determine the patient's desire for the family or designated support person to be kept informed and involved in treatment.
11. Determine the family's or designated support person's ability to support the patient during treatment.
12. Consider the use of a standardized tool for screening and assessment to determine the patient's condition and severity. Tools to consider include the Panic Disorder Screener (PADIS), Patient Health Questionnaire-Panic Disorder (PHQ-PD), Panic Disorder Severity Scale (PDSS), and the Panic Disorder Severity Scale Self-Report (PDSS-SR).³
13. When assessing for panic disorder, understand that a patient can experience panic attacks related to substance use; other anxiety disorders, such as social anxiety; or medical conditions, such as hyperthyroidism or cardiac conditions.²

STRATEGIES

1. Perform hand hygiene.
2. Verify the correct patient using two identifiers.
3. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.¹² If homicidal or suicidal ideation is present, implement appropriate precautions based on the patient's status.
4. Explain the strategies to the patient, family, and designated support person and ensure that they agree to treatment.
5. Maintain a calm, collaborative communication approach, avoiding the use of coercion.
6. Create an environment of trust that allows the development of a therapeutic relationship.
7. Orient the patient to the unit. Include discussion of unit routines, guidelines, patients' rights and expectations, and schedules. Inform the patient that he or she will be checked on frequently throughout the stay.
8. Create an environment that advocates for the patient's needs using an interdisciplinary team. Engage the team in collaborative assessment and treatment planning with the patient.
9. Engage the patient in treatment, including participation in therapeutic groups and individual sessions.

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10. Administer psychiatric medications as ordered and monitor the patient's response to the medications.
11. Monitor the patient's responses and social interactions in the milieu; reinforce appropriate social skills.
12. Implement appropriate precautions based on the patient's status.
13. Respond to crisis in a calm, therapeutic, and nonthreatening manner. Use the least restrictive interventions to prevent harm to patients or staff.
14. Collaborate with the patient, family, designated support person, and team in identifying the physical signs and symptoms the patient experiences at the time of a panic attack to increase his or her awareness that the basis of the attack is anxiety and not a significant medical issue.

Rationale: The signs and symptoms of panic disorder involve primarily physical manifestations that lead patients to seek medical attention for their condition.¹³

15. Explain to the patient, family, and designated support person that panic attacks can happen spontaneously without any apparent trigger and that the experience of the attack can increase the signs and symptoms of panic, impacting the patient's distress.

Rationale: Exploring the patient's experiences during a panic attack and discussing common aspects of panic can be reassuring to the patient who feels he or she is losing control during an attack.⁹

16. Collaborate with the patient, family, designated support person, and team in planning for patient discharge and follow-up care.
17. Provide the appropriate education related to medications, crisis management, and follow-up care to the patient, family, and designated support person at the time of discharge.
18. Explain to the patient, family, and designated support person that ongoing treatment is vital to continuing recovery. Making and keeping follow-up appointments is critical.
19. Perform hand hygiene.
20. Document the strategies in the patient's record.

REASSESSMENT

1. Reassess the patient's pain status and provide appropriate pain management (e.g., medication, relaxation, mindfulness skills).
2. Reassess the patient's experience of panic attacks.
3. Reassess the patient's signs and symptoms of agoraphobia.
4. Reassess the family's and designated support person's understanding of the patient's condition.

EXPECTED OUTCOMES

- The patient does not experience panic attacks.
- The patient does not experience symptoms of agoraphobia.

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- The patient, family, and designated support person have an understanding of the nature of panic disorder and agoraphobia.

UNEXPECTED OUTCOMES

- The patient experiences recurrence of panic attacks.
- The patient refuses to participate in activities due to extreme discomfort about leaving his or her room.
- The patient continues to experience symptoms of agoraphobia.
- The patient, family, and designated support person do not have an understanding of the nature of panic disorder and agoraphobia.

DOCUMENTATION

- Education
- Patient's behaviors and response to interventions
- Patient's progress toward goals
- Assessment of pain, treatment if necessary, and reassessment
- Results of any standardized screening or assessment tools administered
- Results of assessment of cardiac status

ADOLESCENT CONSIDERATIONS

- Agoraphobia and panic disorder do not generally manifest during early adolescence.⁸

OLDER ADULT CONSIDERATIONS

- Agoraphobia is one of the most prevalent anxiety disorders in older adults and may have its onset in late life.⁵

SPECIAL CONSIDERATIONS

- There is an association between panic disorder and mitral valve prolapse (MVP); therefore, patients with panic disorder should be evaluated for MVP.¹⁵
- Pregnant patients with untreated panic disorder have a higher risk of experiencing birth complications, including premature birth, low-birth-weight infants, and infants requiring medical intervention.¹⁶

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*In these skills, a "classic" reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

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