ChatGPT

Comprehensive Profile: Anxiety Disorder Due to Another Medical Condition

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
Source (Textbook & Edition)	**ICD-11** – *International Classification of Diseases 11th Revision* (World Health Organization, 2019 & Clinical Descriptions and Diagnostic Requirements, 2024) [2] [3] ; **DSM-5** – *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* (American Psychiatric Association, 2013) [4] ; **ICD-10** – *ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization, 1992) [5] .
ICD Code	**ICD-11 Code:** 6E63 – *Secondary anxiety syndrome* [6] . (In ICD-11, this falls under "Secondary mental or behavioural syndromes due to disorders classified elsewhere.") **ICD-10 Code:** F06.4 – *Organic anxiety disorder (Anxiety disorder due to known physiological condition)* [7] . *(ICD-10 grouped this with "other mental disorders due to brain damage and physical disease.")*
DSM Code	**DSM-5 Code:** 293.84 [7] – *Anxiety Disorder Due to Another Medical Condition* (DSM-5). This DSM code maps to ICD-10-CM code F06.4 [7] .
Diagnostic Criteria	**ICD-11/ICD-11 CDDR:** Requires **prominent anxiety symptoms** (e.g. excessive fear, panic attacks) that are **judged to be the direct physiological consequence of a medical condition**, based on history, exam or lab evidence [2] [8] . The anxiety is *not* merely a psychological reaction to illness and not explained by delirium or another mental disorder [9] [10] . Symptoms must be severe enough to warrant clinical attention [11] . **DSM-5:** Similar criteria: **A.** Prominent anxiety or panic is the primary clinical feature; **B.** Evidence that the anxiety disturbance is the *direct pathophysiological result* of a medical condition; **C.** Not better explained by another mental disorder; **D.** Not occurring only during delirium; **E.** Causes clinically significant distress or impairment (paraphrased) [12] [13] . In essence, both systems require a causal medical condition and exclusion of other explanations.
Duration Required for Diagnosis	**No minimum duration** is specified in DSM-5 or ICD-11 for this diagnosis. The onset of anxiety should have a **temporal association** with the medical condition (i.e. the medical condition is present *before or at the start of* the anxiety symptoms) [14] . Unlike primary anxiety disorders (which often require ≥6 months of symptoms for diagnoses like GAD), this secondary anxiety is diagnosed based on the *immediate relationship* to the medical condition rather than a set symptom duration. Symptoms may emerge acutely or subacutely following the onset or exacerbation of the medical issue, and they may persist as long as the medical condition remains active.

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Exclusion Criteria / Rule-Outs	**Delirium:** If anxiety occurs *only* during a delirium (acute confusion state), it should not be diagnosed separately [15]. **Substance-induced anxiety:** Rule out that a medication, drug of abuse, or withdrawal is the cause of anxiety; if so, it would be diagnosed as a substance/medication-induced anxiety disorder instead [16]. **Primary anxiety disorders:** If no medical condition is present that can explain symptoms, or if anxiety predates the medical illness, consider primary anxiety (e.g. panic disorder, GAD) rather than this diagnosis [17]. **Adjustment disorder or psychological reaction:** If the anxiety is better explained as an emotional response to having a serious illness (e.g. worry about a cancer diagnosis) without direct physiological cause, then an adjustment disorder with anxiety or another anxiety disorder is more appropriate [18]. **Other mental disorders:** Ensure the symptoms are not better accounted for by other diagnoses (e.g. an existing anxiety disorder, mood disorder, OCD, etc.) [9]. In summary, this diagnosis is only made when anxiety stems from the *physiological effects* of a medical condition, not from substances or purely psychological reactions.

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Common Differential Diagnoses	- **Primary Anxiety Disorders:** Conditions like **Generalized Anxiety Disorder, Panic Disorder, Phobias** should be distinguished. In primary anxiety, no causative medical condition is found; anxiety often has earlier onset and may have psychological triggers. If a direct medical cause is identified, primary anxiety diagnoses are ruled out [17]. - **Adjustment Disorder with anxiety:** If the anxiety is mainly due to **stress about having a medical illness** (e.g. fear, uncertainty, or lifestyle impact of diagnosis) rather than a direct physiological effect, it may be an adjustment disorder or health-related anxiety, not this disorder [18]. For example, intense worry about cancer recurrence is a psychological response, not a "due to medical condition" anxiety unless the cancer (or its treatment) directly triggers physiological anxiety symptoms. - **Delirium or Dementia:** Anxiety symptoms can occur in delirium or in dementia-related agitation, but in those cases cognitive impairment and altered awareness are prominent. In **delirium**, anxiety comes with confusion and fluctuating consciousness; if attention and awareness are significantly disturbed, delirium explains the anxiety [19] [20]. In **dementia**, anxiety can be part of the clinical picture, but if severe cognitive decline is present causing the anxiety, it may be coded as anxiety in dementia rather than a separate secondary anxiety syndrome [21]. (ICD-11 provides a specifier for anxiety symptoms in dementia rather than a separate diagnosis in that scenario [22].) - **Somatic Symptom Disorder or Illness Anxiety Disorder:** These involve anxiety about health and bodily symptoms. In **somatic symptom disorder**, the anxiety is disproportionate preoccupation with physical symptoms; in **illness anxiety** (hypochondriasis), it's fear of having a serious illness. These are psychological in nature – the person's health anxiety, rather than a direct physiological effect of a known illness [23]. If a patient's anxiety revolves around health fears without a confirmed causative illness, or far exceeds what their mild condition would physiologically cause, a somatic-type disorder may be the better fit, not "anxiety due to medical condition." - **Substance/Medication-Induced Anxiety:** Ongoing substance use or withdrawal can cause anxiety symptoms (e.g. stimulant intoxication causing panic, benzodiazepine withdrawal causing anxiety). These should be identified and diagnosed separately. In some cases, a patient could have both conditions (e.g. a heart condition causing anxiety and also abusing alcohol which adds to anxiety). Careful history (including drug screens) is needed [16]. If both a medical condition and substance use are contributing, *both* diagnoses can be given if criteria for each are met [24], but usually one should try to discern the primary driver of symptoms.

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Common Comorbidities	Patients often have comorbidity by virtue of having a medical illness and anxiety together. **The medical condition itself** is a co-occurring condition by definition (e.g. hyperthyroidism + anxiety symptoms). In addition, individuals may have: - **Depressive disorders:** Chronic medical conditions can lead to demoralization or depression alongside anxiety. It's not uncommon for patients with serious illnesses (e.g. heart disease, COPD) to experience both anxiety and depression concurrently, affecting quality of life [25] . - **Other anxiety disorders:** A patient might have a pre-existing anxiety disorder (like GAD) that is exacerbated by the medical condition's effects. However, if a full primary anxiety disorder exists independently, clinicians must decide if both diagnoses are warranted or if symptoms are better explained solely by the medical cause. Sometimes a history of panic or anxiety can coexist, making the presentation more complex (e.g. an asthma patient with panic disorder – their attacks may be triggered by both psychological and physiological factors). - **Substance use disorders:** Some individuals start misusing **alcohol or sedatives** in an attempt to self-medicate the anxiety symptoms caused by their illness. Unfortunately, this can lead to comorbid alcohol or benzodiazepine use disorders. Conversely, long-term substance abuse (like alcohol) can cause health issues (liver disease, etc.) that then contribute to anxiety, tangling causality [26] . - **Sleep disorders:** Insomnia is common due to anxiety, and in some cases the medical condition might cause sleep disturbances too (for example, hyperthyroidism or asthma can disrupt sleep). Chronic insomnia can become a comorbid condition that needs attention in its own right. - **Neurocognitive issues:** If the underlying condition affects the brain (e.g. mild traumatic brain injury, early-stage neurological illness), cognitive symptoms can co-occur. While not "comorbidity" in the usual sense, it means managing anxiety may also involve addressing cognitive rehabilitation or coping strategies for those deficits. - **Somatic symptom disorder:** Occasionally, a patient with a real medical illness that causes anxiety might also have excessive worry about other unexplained symptoms – essentially having a comorbid somatic symptom disorder or health anxiety focusing on aspects of health beyond the known condition. (This is relatively rare, but possible in someone predisposed to health anxiety.) In summary, common co-occurring issues include other mental health conditions like depression or substance misuse, which should be screened for. Importantly, the **medical illness** and its complications are co-morbid by nature and must be managed in tandem with the anxiety [27] .

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Specifiers / Subtypes	**Specified Symptom Type:** DSM-5 allows noting the predominant form of anxiety if relevant (though it does not provide formal specifier codes for this disorder, clinicians often describe whether it manifested primarily as panic attacks, generalized anxiety, obsessive-compulsive symptoms, etc. [28] [29]). ICD-10 explicitly noted that the presentation can resemble generalized anxiety, panic disorder, or a mix of both, but caused by an organic factor [5]. For example, one might document "Anxiety Disorder Due to Hyperthyroidism, with panic attacks" if panic episodes are the main feature. **Underlying Condition Coding:** Both DSM-5 and ICD-11 require that the underlying medical condition be listed alongside. In DSM-5, the clinician should indicate the *specific* medical condition (e.g. Anxiety Disorder Due to Pheochromocytoma). In ICD-11, one uses a "cluster code" or additional code to identify the causing condition [30]. Essentially, it's a two-part diagnosis: the anxiety disorder plus the medical disease causing it. **Severity:** Neither DSM-5 nor ICD-11 provides standardized severity levels (like "mild/moderate/severe") for this diagnosis. The severity is generally implied by the level of distress/impairment and the intensity of symptoms. Clinicians can describe severity qualitatively (e.g. "severe anxiety due to Cushing's disease") or use anxiety rating scales to quantify severity. **Course specifiers:** DSM-5 does not list course specifiers (like "acute" vs "chronic") specifically for this disorder, but one might note if the condition is acute (e.g. anxiety during a transient medical condition) or chronic (anxiety in a chronic illness). **Remission status:** Because this disorder often remits if the medical issue is treated, clinicians may not formally label "in remission," but can note if anxiety symptoms have resolved after medical treatment.

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Severity Levels	There are no official numeric "severity" scales (unlike some disorders that have mild/moderate/severe specifiers) in DSM-5 or ICD-11 for this diagnosis. The **severity is assessed clinically** by evaluating how intense the anxiety symptoms are and how much they interfere with functioning [31] [32] . In practice: **Mild:** Anxiety symptoms are present but manageable and cause minimal impairment. (E.g., occasional episodes of moderate anxiety when the medical condition flares, but patient functions mostly normally.) **Moderate:** Anxiety is distressing and frequent, with clear impact on daily life or ability to concentrate, but the patient can still perform basic responsibilities with effort. **Severe:** Anxiety symptoms (panic attacks, constant worry, autonomic symptoms) are debilitating, causing significant impairment in work, social activities, or self-care. The person might be unable to work or might frequently seek emergency care for anxiety symptoms. **Clinically severe cases warrant treatment immediately**, as noted in ICD-11 ("symptoms sufficiently severe to warrant specific clinical attention" is required for diagnosis) [33] [34] . It's worth noting that severity often correlates with the severity of the underlying medical condition as well – a more severe illness (e.g., pheochromocytoma secreting high adrenaline levels) can produce more severe anxiety symptoms. Clinicians may use standardized scales (like HAM-A or GAD-7) to help gauge baseline severity and track changes (e.g., HAM-A score: mild <18, moderate 18-24, severe >25 on that scale).
Age of Onset	This disorder can occur **at any age** since medical conditions can cause anxiety in children, adults, or the elderly. However, it is more frequently identified in **middle age or later adulthood**, because that's when people more commonly develop medical illnesses that have anxiety as a symptom (e.g. cardiovascular issues, endocrine disorders). In fact, a new onset of panic or anxiety symptoms in an older adult with no psychiatric history often points to an organic cause [35] . Clinicians are taught to be especially alert to late-onset anxiety (onset in one's 40s, 50s or later) as a red flag for an underlying medical condition [36] . In younger individuals, it's less common but possible. For example, a child with undiagnosed hyperthyroidism or a teenager with supraventricular tachycardia might experience anxiety symptoms due to those conditions. But generally, **primary anxiety disorders** (like separation anxiety, panic disorder, etc.) tend to have earlier onset (childhood to early adulthood), whereas **anxiety due to a medical condition** often aligns with the timeline of the medical illness (which might be later). Therefore, age of onset is variable and tied to when the person's medical condition emerges, but if someone develops significant anxiety *for the first time* at a later age, a medical cause should be strongly considered.

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Gender Prevalence	There is no specific male/female prevalence data unique to this disorder in the literature; it largely depends on the epidemiology of the underlying medical conditions. **Overall, anxiety disorders** tend to be more common in females (roughly 2:1 in many anxiety diagnoses). Likewise, many medical causes of anxiety have gender skews: for instance, **thyroid disorders** (like Graves' disease or Hashimoto's thyroiditis) are more common in women and can lead to anxiety symptoms [37]. Pheochromocytoma has no strong gender bias, while cardiovascular diseases causing anxiety (like arrhythmias) might be more common in males at certain ages. Because of these factors, one might *expect* to see slightly more cases in females (due to both higher baseline anxiety prevalence and illnesses like hyperthyroidism and lupus being more common in women). However, this is not a firm rule. For example, if an anxiety syndrome is due to COPD or coronary artery disease, those causes might be more common in older males (historically, though the gap is closing). In sum, **gender prevalence is not well characterized** for this secondary anxiety diagnosis. It's best to consider the prevalence of the specific medical condition: e.g., if it's anxiety due to Cushing's syndrome, it will mirror Cushing's gender distribution. Both men and women can and do experience anxiety as a result of medical conditions. Clinicians should maintain equal vigilance in assessing medical contributors to anxiety in all genders.

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Typical Course/ Progression	The course of this disorder **depends largely on the course of the underlying medical condition**. Key patterns include: **Acute onset:** The anxiety may begin rather suddenly when the medical condition arises or acutely worsens. For example, anxiety might spike during a thyroid storm or an asthma exacerbation. **Concurrent progression:** While the medical illness is active or untreated, anxiety symptoms persist. There is often a close parallel: when the medical condition flares up, anxiety intensifies; when the condition improves, anxiety diminishes [32] [38] . **Remission if cause is treated:** If the medical issue is successfully treated or resolves, the anxiety disorder often remits. For instance, once hyperthyroidism is brought under control, the physiological triggers for anxiety abate and the anxiety symptoms typically disappear over days to weeks. In many cases, *treating the medical cause effectively "cures" the anxiety disorder* [39] . **Chronic course if cause persists:** If the medical condition is chronic (e.g., chronic pulmonary disease, diabetes with frequent hypoglycemia, etc.), the anxiety may become a chronic or recurring problem. Patients might have long-term anxiety management needs as they cope with ongoing medical issues. The anxiety may wax and wane – improving during stable phases of the illness and worsening during exacerbations. **Residual anxiety:** Sometimes, even after the medical condition is treated, a patient might continue to experience some anxiety. This could be due to a learned or conditioned fear response that lingered, or due to permanent changes (e.g., neurological changes after encephalitis). In those cases, the anxiety might transition into a primary anxiety disorder or require ongoing treatment. Without treatment (medical or psychological), the anxiety tends to persist or even become more chronic [40] . Once appropriate interventions are in place, the **prognosis is often good** (see Prognosis below): many patients have a full resolution of anxiety when the medical issue is resolved, or at least significant improvement if the medical issue can be managed.

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Core Symptoms	The core feature is **excessive anxiety or fear** directly caused by physiological changes. In practical terms, the person experiences symptoms very similar to primary anxiety disorders, but in this case *triggered by a medical condition's effects*. Common core symptoms include: **Persistent worry and nervousness:** The individual feels a sense of dread or apprehension. For example, they may report constant anxiety or heightened worry that they often can't attribute to life problems – it's "just there" due to their body's state [41] . **Episodes of intense fear (panic attacks):** Many patients experience panic attacks – sudden surges of terror often accompanied by physical symptoms. These can occur "out of the blue" (e.g., an arrhythmia or pheochromocytoma causing a spontaneous panic episode with no external trigger) [42] [43] . **Physical tension and restlessness:** There is often an inability to relax, feeling keyed-up or on edge. Muscle tension is common, as are tremors or an internal feeling of jitteriness [44] . **Hypervigilance:** Patients may be acutely aware of their bodily sensations, especially if they've learned those signal something (like noticing heart palpitations immediately). They may startle easily and feel in a constant "fight or flight" mode. **Difficulty concentrating:** High levels of anxiety make it hard to focus or cause "mind going blank" moments [41] . Patients might appear distractible or overwhelmed by racing thoughts. Importantly, **the anxiety is directly tied to the medical condition's activity** – e.g., a patient might say, "Whenever my blood sugar drops, I feel a wave of panic," or "I get extremely anxious right before my lupus flares up physically." The presence of a medical cause is what differentiates these symptoms as "secondary." In the moment, however, the subjective experience of the anxiety (fear, worry, panic) is much like any anxiety disorder.

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Cognitive Features	**Maladaptive thoughts and fears** accompany the physiological anxiety. Common cognitive features: **Catastrophic interpretation:** Patients often interpret the physical symptoms in catastrophic ways. For example, during an episode of tachycardia from a medical cause, the patient might think "I'm going to die" or "Something horrible is happening," which amplifies the anxiety [45] . Even if part of their mind knows they have a medical condition, the subjective terror can override rational thought in the moment. **Excessive worry about health or episodes:** Many develop a **strong fear of the next attack or symptom episode**. They may constantly worry "When will the next panic attack hit?" or "What if my heart starts racing when I'm out?" This anticipatory anxiety can persist even outside acute episodes. **Difficulty concentrating and memory:** As noted, anxiety impairs focus. Patients report that when their anxiety is high, they cannot concentrate on tasks or conversations. They might also be forgetful during those times, as attention is consumed by worry (this is a cognitive effect of anxiety). **Intrusive thoughts:** If the anxiety manifests with obsessive-compulsive features (as it can), the person might have intrusive thoughts related to harm, contamination, or other themes, which they recognize as their mind's product but cannot easily dismiss [46] . These thoughts provoke more anxiety until addressed. **Reduced insight during peaks:** While generally patients know they have a medical illness causing their feelings, during high anxiety they might temporarily lose sight of that and feel convinced of impending doom (e.g., "This feels just like when I had my heart attack – I'm sure I'm having another one right now!" even if tests are normal). After the episode, they often regain insight that anxiety was at play. In summary, cognitively these patients often battle **fearful anticipation** and catastrophic thinking tied to body sensations. They may also develop a heightened focus on bodily processes – a cognitive hyper-vigilance to any symptom – which can feed a vicious cycle of noticing normal fluctuations and worrying about them. Cognitive-behavioral therapy often targets these cognitive patterns, helping patients reinterpret sensations more accurately and break the catastrophic thought cycle.

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Emotional Symptoms	Beyond fear and worry, patients experience a range of emotional responses: **Fear/Dread:** The hallmark emotion is intense fear – sometimes free-floating, sometimes linked to specific bodily sensations. Patients describe feeling a sense of impending doom or panic seemingly out of nowhere due to their condition's effects [31]. This fear can be disproportionate to any actual external danger (since the trigger is internal/physiological). **Irritability:** Chronic anxiety can make patients irritable or short-tempered. They may be easily frustrated or agitated, especially if they're constantly on edge. Minor annoyances might produce an outsized emotional reaction because their baseline arousal is so high [47]. **Helplessness or depression** (secondary): Emotionally, some patients feel helpless or demoralized – "my body is making me feel this way and I can't control it." Over time, dealing with persistent anxiety symptoms can lead to demoralization or coexisting depressive feelings (though if full depression sets in, that would be a comorbidity). They might cry easily or feel hopeless during severe episodes. **Embarrassment/Shame:** Particularly if the anxiety episodes are visible to others (like panic attacks in public or noticeable shaking), patients can feel embarrassed or ashamed. They might fear that others think they're "weak" or "crazy," not understanding there's a medical cause. This emotional response can lead to avoidance of social situations out of shame. **Anhedonia:** While not a direct symptom of anxiety, emotionally patients might lose enjoyment in activities because they're too preoccupied by anxiety or fear triggering symptoms. This is more related to comorbid emotional impact, but is often reported – they can't relax to enjoy things because anxiety intrudes. In summary, **the emotional tone is dominated by fear and tension**, with irritability and feelings of helplessness sometimes emerging as secondary emotions. Patients often say they feel "constantly on edge" or describe it as "dread that I can't shake." These emotional symptoms improve as the anxiety is brought under control and once patients feel safer in their bodies again.

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Behavioral Symptoms	Anxiety due to a medical condition can drive a variety of behavioral changes: **Avoidance behaviors:** The person may begin avoiding situations they associate (rightly or wrongly) with their anxiety episodes. For example, if physical exertion (exercise) tends to trigger palpitations and panic, they might stop exercising or avoid climbing stairs. If being alone is scary in case a medical emergency happens, they may cling to others or avoid being without a companion. **Avoidance** can generalize in maladaptive ways, limiting activities and independence. **Checking and health-related behaviors:** Some patients frequently check their vitals or seek reassurance. For instance, they might take their pulse or blood pressure repeatedly, or use a home glucose monitor excessively out of anxiety. They may also repeatedly seek medical evaluations (ER visits, doctor calls) whenever symptoms arise, which is understandable but can become excessive if anxiety-driven. **Compensatory behaviors:** If their anxiety presents with OCD-like elements, they might develop **rituals** aimed at preventing symptoms. For example, a patient might only sleep sitting up because they believe it prevents palpitations, or they may engage in compulsive counting, checking, or other rituals to manage anxious thoughts [29]. While these behaviors temporarily reduce anxiety, they reinforce the anxiety in the long run. **Restlessness and fidgeting:** On a more basic level, many are visibly restless – pacing, fidgeting, inability to sit still, foot tapping. This psychomotor agitation is a common behavioral manifestation of the internal anxiety [44]. Family might notice the person is always "keyed up," wringing their hands or looking on edge. **Social withdrawal:** Some people withdraw from social interactions or work because they fear having anxiety symptoms (or medical symptoms) in front of others. They might stop going out with friends, skip work meetings, or isolate at home to avoid potential embarrassment or panic. This withdrawal can lead to further functional impairment and feelings of loneliness. Behaviorally, there can be an overlap with how primary anxiety disorder patients behave. The key is these behaviors are often *reinforced* by the real physical sensations they experience – e.g., avoiding exertion genuinely might stave off an episode of tachycardia-induced panic, so it **negatively reinforces** the avoidance. Part of treatment will be gradually reversing these behaviors in a safe manner.

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Somatic/Physical Symptoms	**Prominent physical (somatic) symptoms** of anxiety are typically present – often *indistinguishable from those in primary anxiety disorders*, though sometimes unusually intense because of the medical cause. Common physical signs include: **Cardiovascular:** *Palpitations* (awareness of heartbeat), pounding heart, or rapid heart rate are very common [42]. Patients often describe chest pain or chest tightness during panic-like episodes [43]. They may fear these are heart attacks. (In this disorder, the heart racing is often directly triggered by the medical issue – e.g., thyroid hormone excess or an arrhythmia.) Blood pressure may spike during anxiety episodes; some experience flushing or, conversely, cold clammy extremities. **Respiratory:** *Shortness of breath, hyperventilation,* or a feeling of choking/smothering often occur [43]. The patient might sigh or gasp for air. If the underlying condition is pulmonary (like asthma or COPD), there is an interplay – the illness causes dyspnea which triggers panic, which causes further hyperventilation. Even in non-pulmonary causes, hyperventilation is common as a physiological anxiety response. **Neurologic:** *Dizziness, lightheadedness, trembling, paresthesias (numbness or tingling)* are frequently reported [48] [43]. They may feel faint or unsteady. Some get tunnel vision or feel detached (derealization) during high anxiety. Fine motor tremors can be visible (e.g., a tremor in hyperthyroidism-related anxiety). Headaches or muscle tension headaches can result from prolonged anxiety. **GI and autonomic:** *Sweating* (diaphoresis), sometimes profuse, is common [44]. *Nausea, "butterflies," dry mouth, or even vomiting* can occur with acute anxiety. Some experience diarrhea or frequent bowel movements when anxious. Conversely, others might feel a lump in throat or need to urinate often under stress. These autonomic signs are part of the fight-or-flight activation. **Muscular:** *Muscle tension, aches, or twitching* – for example, they might have shaking hands or a persistent tension in the neck/shoulders. In generalized anxiety presentations, patients often report feeling physically fatigued and sore due to constant muscle tension [41]. During a full-blown panic attack, a patient might have many of these at once: e.g., **pounding heart, chest pain, dizziness, sweating, trembling, shortness of breath, choking sensation, numbness, chills or hot flashes** [43]. These symptoms can be so severe that, as noted, patients often seek emergency medical care fearing a life-threatening event [49]. It's important for clinicians to evaluate these physical symptoms medically (to ensure the underlying condition and not, say, a new cardiac event). But once it's established as anxiety due to the known condition, patients can be reassured that these intense bodily sensations, while scary, are not dangerous in themselves but rather a byproduct of their condition's effect on the body.

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Insight / Awareness of Illness	**Insight can vary**: Generally, patients understand they are anxious, but may not immediately recognize that the medical condition is triggering the anxiety. Often, once diagnosed, they retrospectively connect the dots ("I realize now my thyroid problem was making me anxious"). Prior to that, they might feel bewildered by the onset of anxiety ("I feel anxious for no reason – it just hits me"). Many patients initially attribute symptoms to purely physical causes – for example, chest pain and panic feelings prompt, say, a cardiology workup (as they should), and only after negative cardiac results and finding hyperthyroidism does the patient realize the anxiety was from thyroid, not a heart attack. In **acute episodes**, insight can diminish: during a panic attack or wave of anxiety, patients often feel **out of control** and truly believe something awful is happening physically, even if they "rationally" know about their condition. For instance, a patient with known pheochromocytoma might still panic and think "this time I will die" when a surge comes, despite knowing the diagnosis – because the fight-or-flight sensations override rational reassurance. Once properly educated, **most patients gain good insight** that their anxiety is linked to the medical condition and is not a standalone psychiatric illness or a sign they are "going crazy." They often feel relieved to have an explanation. However, this insight doesn't automatically stop the anxiety; it just helps them and their family contextualize it. One caveat: patients with **underlying neurological conditions** (e.g., certain forms of encephalopathy) might have impaired insight if cognition is affected. But typically, for conditions like endocrine or cardiac causes, cognitive capacity is intact and insight is preserved outside of anxiety spikes. Patients usually become active collaborators in treatment once they understand the mechanism ("My adrenal tumor causes adrenaline rushes that make me panic"). They might still have some *health anxiety* – e.g., worry that the medical condition could harm them – but they know the anxiety symptoms per se are not an additional mysterious illness. They also learn to differentiate *psychological anxiety* versus *appropriate concern*: for example, they may say "I know my heart tests are normal now, so when I feel my heart race, I remind myself it's just the anxiety from my condition" – an indicator of insight developing [50] . Overall, insight tends to be **good** once the diagnosis is established, though at the peaks of anxiety episodes it can feel as if the body "has a mind of its own," which is a challenging experience for patients.

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Cultural Considerations in Presentation	**Cultural factors** can influence how anxiety symptoms are expressed and perceived, though the physiological basis remains the same. For example, in some cultures individuals may emphasize **somatic complaints** over emotional ones due to stigma against mental illness; thus a patient might report palpitations and fatigue but be reluctant to label it "anxiety." This can complicate diagnosis unless the clinician is attuned to these communication differences [51]. Conversely, some cultural contexts readily accept mind-body interplay, which may make it easier for patients to acknowledge "nerves" or anxiety as part of their illness. **Somatization tendency:** Research suggests that certain cultural groups (e.g., some Asian, African, or Latin American contexts) may present anxiety and depression predominantly with physical symptoms (like headaches, chest pain) rather than verbalizing worry [51]. In such cases, a secondary anxiety syndrome might be initially missed or attributed purely to physical illness unless specifically probed. Clinicians should gently ask about worry, fear, or tension in culturally appropriate ways (perhaps framing it as "stress" or "nervousness" if those terms are more acceptable). **Cultural explanations:** Patients might have culturally-specific explanations for their symptoms. For instance, in certain cultures, palpitations and panic might be attributed to "evil eye" or spiritual causes. If a patient believes their anxiety is due to a curse or spiritual imbalance, they may first seek traditional healers. It's important for clinicians to respect such beliefs while still evaluating medical causes. Once a medical cause is identified, integrating that explanation with the patient's belief system (for example, "your thyroid gland is overactive, which in your tradition might be seen as an imbalance of heat/energy") can improve acceptance of treatment. **Role of stigma:** In cultures with high stigma toward mental illness, patients and families might prefer to view the anxiety as purely part of the physical illness (which in this case is partially true!). This can be advantageous (reducing blame on the patient) but might also delay psychiatric consultation. Emphasizing the medical nature of the anxiety ("it's your illness causing this, not a personal weakness") can be very helpful in these settings. No culture is immune to this disorder, but the *presentation and help-seeking behavior* may vary. Clinicians should use culturally sensitive communication, possibly involving cultural mediators, to ensure the patient and family understand the diagnosis and are agreeable to treatment, whether it's medication or therapy. In summary, cultural norms influence whether anxiety symptoms are reported as emotional vs physical and how readily patients accept psychological treatments, but the underlying biological phenomenon crosses cultures.

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Genetic Factors	There isn't a specific genetic profile for "anxiety due to another medical condition" since it is secondary to various illnesses. However, genetics can play an indirect role: **Genetics of the underlying condition:** Many medical conditions that cause anxiety have genetic components. For example, *pheochromocytoma* can be part of hereditary syndromes, *thyroid diseases* often run in families, and conditions like *Wilson's disease* (a genetic copper metabolism disorder) cause anxiety symptoms [52]. If a patient has a genetically driven illness, they inherently have a risk for the anxiety that accompanies that illness. So familial patterns of the illness can indirectly mean familial occurrence of this anxiety (e.g., several family members with hyperthyroidism all experienced anxiety during their thyrotoxic phase). **Genetic predisposition to anxiety:** Apart from the illness itself, some people have an inherited temperament that is more anxiety-prone (estimated heritability of anxiety disorders is around 30-50%). If someone with such a predisposition develops a medical trigger, they might have a more severe anxiety response. Conversely, a genetically low-anxiety individual might experience milder anxiety even with the same medical condition. So, genes influencing serotonin, norepinephrine, or autonomic reactivity could modulate the intensity of the anxiety response to a given medical provocation. **Family history:** We often find that patients who develop significant anxiety with a medical illness might also report "My mother was an anxious person" or other family anxiety histories. While anecdotal, this suggests a familial vulnerability. This doesn't change the diagnosis, but in families with high anxiety sensitivity, any stressor (including medical) can trigger bigger anxiety. Clinically, if a patient has a strong family history of anxiety disorders, one might be more vigilant as they could be prone to developing a chronic anxiety disorder even after the medical issue is treated. In summary, no gene "for" secondary anxiety is identified, but **genetics of both the medical disorders and of anxiety regulation** influence who gets this disorder and how severely. It's an interplay of inherited risk and environmental trigger (the medical condition).

Neurobiological Factors	The neurobiology of this condition essentially mirrors the pathways of anxiety activation, with the key difference that a **medical pathology initiates the cascade**. Some relevant factors: **Autonomic Nervous System activation:** Many medical conditions provoke a sympathetic "fight or flight" response. For example, hyperthyroidism increases beta-adrenergic activity – leading to tachycardia, tremor, etc., which are mediated by norepinephrine. A pheochromocytoma periodically releases surges of catecholamines (epinephrine/norepinephrine) causing immediate panic-like symptoms [53]. Hypoglycemia triggers release of adrenaline as a counter-regulatory measure, which can cause shakiness, sweating, anxiety. Thus, in many cases the **ANS is the final common pathway** for symptoms. **HPA Axis and stress hormones:** Some conditions (like Cushing's disease with excess cortisol, or severe chronic illness) lead to elevated stress hormones. High cortisol can produce mood and anxiety symptoms by its effects on the brain (amygdala hyper-responsiveness, hippocampal changes). Conversely, adrenal insufficiency can also cause anxiety (perhaps via electrolyte changes and adrenergic dysregulation). The hypothalamic-pituitary-adrenal (HPA) axis may be perturbed in these medical scenarios, leading to anxiety biology. **Neurotransmitter changes:** Certain medical conditions might alter neurotransmitter levels. For instance, some **autoimmune encephalitides** (brain inflammation) or the effect of **cytokines** in chronic infection can influence serotonin and glutamate systems, manifesting as anxiety or agitation. Vitamin B12 deficiency (a metabolic cause) can lead to neurologic changes and mood/anxiety disturbances by disrupting myelination and possibly monoamine synthesis. Though research is ongoing, we suspect that medical conditions can secondarily affect **brain regions like the amygdala, locus coeruleus, and prefrontal cortex** through these neurotransmitter or immune pathways, producing anxiety. **Specific brain lesions or dysfunction:** If anxiety is due to a neurological condition (like a tumor, stroke, or MS lesion), the location matters. Lesions in the temporal lobe or limbic circuits, for example, can produce anxiety symptoms or even panic attacks. A right-hemisphere stroke has been associated in some cases with new-onset anxiety (though depression is more common). In Wilson's disease, copper deposition in the brain (basal ganglia) may underlie neuropsychiatric symptoms including anxiety [52]. Essentially, any brain insult in areas governing emotion (amygdala, hippocampus, frontal cortex) can manifest as anxiety if the circuitry is disturbed. **Physiological feedback loops:** Chronic illnesses can create a feedback loop of anxiety. For instance, difficulty breathing in COPD leads to CO_2 retention, which can cause an "air hunger" panic sensation; the resulting hyperventilation blows off CO_2, altering blood pH, which can further cause lightheadedness and tingling, reinforcing panic. So the body's attempt to compensate can create a vicious cycle at the physiological level. Recognizing these loops helps in treatment (like using a fan or breathing retraining for COPD anxiety). In summary, **the medical condition sets off a cascade** that converges on the brain's anxiety response systems. Whether via hormones (thyroid, adrenaline), metabolic disruptions, or direct neural injury, the end result is overactivation of fear circuitry. This is why treating the condition (e.g.,

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	beta-blockers to blunt adrenergic response, or treating hyperthyroid) can significantly reduce the anxiety – it interrupts the neurobiological trigger.

Psychological Factors	While this disorder is defined by a physiological cause, psychological factors still influence its development and course: **Personality and coping style:** An individual's baseline coping skills and personality will shape their experience. Someone with a tendency toward health anxiety or negative interpretation of symptoms will likely have more intense anxiety responses. For example, a person who naturally catastrophizes may perceive a mild symptom from their condition as catastrophic, amplifying anxiety. Meanwhile, a person with strong resilience and coping might weather the symptoms with less panic. Thus, pre-existing anxiety traits (neuroticism) can heighten the reaction [54] . **Previous experiences:** If the patient has a history of trauma or prior frightening medical episodes, these can set psychological groundwork. For instance, a person who nearly drowned (trauma) might have an exaggerated anxiety response to any sensation of shortness of breath from, say, asthma, because it unconsciously echoes that trauma. Past **panic attacks** or anxiety disorders can also "prime" the patient – they may quickly interpret sensations in an anxious way because they've felt similar before in a panic context. **Health beliefs:** People who have strong beliefs about health can be affected. If someone believes "any heart palpitations mean I could die," they'll understandably react with enormous anxiety when they feel palpitations. Cognitive beliefs about illness and death influence anxiety intensity. Those who believe their illness is extremely dangerous or unpredictable will feel more anxiety. Education can help reframe these beliefs to more adaptive ones (e.g. "palpitations are uncomfortable but not immediately deadly in my condition"). **Attention and misinterpretation:** Psychologically, some patients become *hyper-focused* on internal sensations (interoceptive attention). This can create a biofeedback loop where even normal variations are noticed and worried about, sustaining anxiety [55] . For example, feeling one skipped heartbeat leads to spiraling thoughts "Here it goes, I'll have a huge episode," which itself triggers anxiety and potentially more symptoms. Cognitive-behavioral models describe this misinterpretation of benign symptoms as a key psychological factor we can modify with therapy. **Stress and emotional context:** General life stress can worsen any anxiety. If a patient is also dealing with external stressors (job loss, family conflict), their psychological bandwidth to cope with the medical symptoms is reduced, often leading to heightened anxiety. Moreover, some may subconsciously channel broader anxieties into focus on their health. For example, an individual under high work stress might find their anxiety attaching to their illness ("I'm constantly anxious about my blood pressure"), as a displacement of sorts. Treating overall stress levels can help mitigate this. In short, **psychological makeup and stress** modulate the expression of this disorder. The physiological cause is necessary, but two patients with the same medical trigger might have different anxiety severity depending on these psychological factors. That's why interventions like CBT (which address thoughts and coping) are beneficial even though the root cause is medical – they help break the cycle of catastrophic thinking and avoidance that can compound the physiological anxiety.

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
Environmental / Social Factors	The environment and social context can significantly affect these patients: **Stressful environment:** External stress (like a high-pressure job, family conflict, or caregiving responsibilities) can exacerbate anxiety symptoms. The body's physiological anxiety from the medical condition can be amplified if the person is also under psychosocial stress. For example, a patient with diabetes who frequently has hypoglycemic anxiety episodes will handle them worse if they work in a chaotic environment or lack support. Stress management and possibly modifying environmental stressors (where possible) are an important part of care. **Exposure to toxins or medications:** Environmental exposures can also play a role. For instance, chronic exposure to organophosphate pesticides can cause anxiety and restlessness by their effects on the nervous system [56]. Similarly, high caffeine intake (sometimes considered a "social" habit) will worsen anxiety symptoms – many patients inadvertently aggravate their condition by consuming caffeine, energy drinks, or certain supplements that increase heart rate. Reducing these environmental triggers (caffeine, stimulant decongestants, etc.) is often recommended [57]. **Social support vs isolation:** Having a strong social support network tends to buffer anxiety. Patients with understanding family or friends who can assist during episodes (or even just provide reassurance and help with practical matters) often cope better. Conversely, those who are socially isolated may experience more fear because they worry "what if something happens and I'm alone?" This can increase baseline anxiety. Also, isolation leaves them ruminating more on symptoms. Encouraging connection – whether through family, friends, or support groups – is beneficial. **Socioeconomic factors:** Practical environment factors like access to healthcare, stable housing, and employment matter. A patient worrying about how to afford treatment or who has unstable housing (and thus irregular access to medication or diet control) will have additional anxiety triggers. For instance, not affording thyroid meds could lead to fluctuating symptoms and constant anxiety about it. Social determinants of health often need addressing (referrals to social services, financial counseling) as part of a comprehensive approach. **Cultural environment:** As above, the cultural environment (stigma level, community beliefs) can influence whether patients seek help or hide symptoms. In a community that frowns on discussing mental health, patients might not voice their anxiety until it's severe, delaying treatment. In summary, a supportive, low-stress environment can help mitigate the expression of this disorder, while a high-stress or low-support environment can worsen outcomes. Part of treatment planning often includes educating family (to create a supportive home environment) and advising on lifestyle adjustments (e.g., avoiding environmental anxiogens like caffeine or certain drugs).

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
Cultural / Religious Factors	**Religious and spiritual beliefs** can influence how patients cope and interpret their anxiety. While no particular religion is associated with higher incidence of this disorder, a patient's faith can be a source of comfort or, in some cases, conflict: **Faith-based coping:** Many individuals use prayer, meditation, or other spiritual practices to cope with anxiety. A religious patient might pray for relief during panic attacks or find solace in believing that a higher power is watching over their health. This can be positive, as it provides comfort and meaning, and can be encouraged as part of a holistic coping strategy (as long as it doesn't lead them to refuse medical care). **Belief vs. medical explanation:** Some highly religious individuals might initially frame their experience in spiritual terms (e.g., "I feel like I'm being tested by God" or "possessed" or "cursed"). It's important to integrate medical explanations in a way that doesn't dismiss these beliefs. For example, one could say, "Your body has this condition which is causing these feelings – and perhaps this is indeed a test of faith in how you handle it. Using the treatments available could be seen as part of God's provision for you." Aligning treatment with their belief system can improve acceptance. **Guilt or stigma:** In certain religious communities, having anxiety or what appears to be "emotional weakness" might be stigmatized or seen as a lack of faith. A patient might feel guilt ("If I truly trusted God, I wouldn't be anxious"). They might thus under-report anxiety or avoid psychological help, opting only for prayer. It's beneficial for healthcare providers to reassure them that anxiety in this case has a real medical basis (not a moral failing) and that seeking treatment is not a sign of weak faith. Sometimes involving a trusted faith leader to support the idea of treatment can help. **Religious manifestations of anxiety:** There are culture-specific or religious-specific anxiety expressions (like *"khyâl attacks"* in Cambodian culture or *"Jinn possession"* interpretations in some Islamic contexts). If relevant, these should be understood empathetically. The underlying physiology is the same, but the patient's explanation may be couched in religious terms. Working with cultural/religious counselors can assist in bridging understanding. Overall, religion can be a **coping resource** for many – offering community support, hope, and practices like mindfulness, which can reduce anxiety. Encouraging any benign spiritual practice that calms the patient (meditation, attending services if able, etc.) is helpful. Clinicians should be cautious not to dismiss or pathologize religious behavior unless it clearly is delusional or excessive. In *some* cases, very devout patients might focus their anxiety into religious obsessionality (e.g., scrupulosity – obsessive fear of sin, etc.), but that tends to fall under OCD or other categories. For this disorder specifically, religious factors mainly shape coping and willingness to accept interventions rather than being etiological.

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
Developmental History	**Early life and developmental factors** can influence how a person responds to later medical-triggered anxiety: **Childhood anxiety or temperament:** If the individual had an anxious temperament as a child or a history of anxiety disorders earlier in life, they may be more prone to intense anxiety when a medical stressor occurs. For instance, someone who had separation anxiety disorder or was a particularly anxious child might have a sensitized stress response system. So when a medical issue arises decades later, their developmental predisposition kicks in, yielding a stronger anxiety reaction than someone without that history [54] . **History of medical issues in childhood:** Early experiences with illness can shape coping. A person who was frequently ill or hospitalized as a child might either: (a) have learned effective coping and thus handle current symptoms calmly, or (b) carry trauma and fear from those experiences, making current symptoms trigger those childhood fears. For example, an adult who had childhood asthma attacks may find that current shortness of breath from any cause immediately triggers panic because it reminds them (implicitly) of fighting to breathe as a child. **Attachment and support in development:** Those who grew up with stable support and learned good stress-management might fare better. Conversely, adverse childhood experiences (abuse, neglect) can lead to heightened baseline anxiety and poor stress regulation (dysregulated HPA axis), which can amplify any anxiety later on, including that from medical conditions. **Developmental stage of onset:** If the medical condition (and anxiety) begins in adolescence, it can impact development – causing school avoidance or social withdrawal during key formative years, which may have long-term effects if not addressed. In older adults, developmental stage issues relate to loss of roles or independence; sudden anxiety in an elder could threaten their independent living (family may question if they can live alone, etc.), which can be a blow to their developmental task of maintaining autonomy. In summary, a thorough developmental history (including any prior psychiatric issues and how the person coped with stress while growing up) provides context. While the immediate cause is medical, those developmental factors can determine resilience or vulnerability. Clinically, if someone has a robust developmental background, one might expect them to recover faster with treatment, whereas someone with a troubled background might need more psychotherapy to build coping skills that were never fully developed.

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Family History	**Family history is relevant in two ways:** the medical side and the psychiatric side. **Family history of the medical condition:** Many causative illnesses have familial patterns. For example, if a patient has *thyrotoxicosis*, one might find several family members with thyroid disease. If the family is aware, they might even recognize the symptoms ("Oh, your aunt got really nervous when her thyroid was high too"). A family history of similar presentations can validate the patient's experience and provide insight ("this runs in our family"). It also means we might screen other family members if appropriate (though that's more about the medical condition than the anxiety per se). **Family history of anxiety or mood disorders:** As mentioned under genetic factors, a familial tendency to anxiety can increase one's propensity. If the patient says many relatives are "nervous types" or have diagnosed anxiety/depression, it suggests a lower threshold for developing significant anxiety. They might have learned some anxious behaviors from family modeling as well. For instance, if a parent responded to illness with great anxiety, the patient may have internalized that response style. In families with high anxiety, discussions about symptoms can sometimes be exaggerated or catastrophic, potentially feeding the patient's own anxiety interpretation. **Family attitudes toward illness:** Family beliefs impact the patient. If the family downplays symptoms ("it's not a big deal, tough it out"), the patient might feel pressure not to express anxiety, leading to internalizing it more. If the family is overly protective or alarmist ("Oh no, your heart fluttered – this is terrible!"), it can reinforce the patient's fears. Understanding the family's approach helps tailor psychoeducation: sometimes we educate family to strike a balance – to take the condition seriously but not panic at every symptom. **Familial support vs dysfunction:** A supportive family that encourages treatment, helps with logistics (appointments, medication routines), and provides emotional comfort can improve outcomes. A family with dysfunction (high conflict, denial of illness, etc.) can worsen patient anxiety. For example, if family members don't believe the patient's symptoms ("it's all in your head"), the patient can become more anxious and isolated. In contrast, if family members are calm and reassuring anchors, the patient often feels safer and less anxious. We often ask about family psychiatric history as part of assessment – if it's positive, we remain alert that the patient could have an underlying predisposition or even a co-occurring primary anxiety. We also gauge how family is reacting to the patient's illness now. Intervening via **family education** can sometimes transform a home environment from one that inadvertently fuels anxiety to one that helps quell it.

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
Structured Interviews	There isn't a dedicated structured interview solely for this disorder, but standard psychiatric diagnostic interviews and medical history-taking are used together. Key tools and approaches: **SCID-5 (Structured Clinical Interview for DSM-5):** The SCID has sections for anxiety disorders including an "Anxiety Disorder Due to Another Medical Condition" criteria checklist. A clinician using SCID will systematically verify each DSM criterion (as listed above) – e.g., they would ask about the presence of panic/anxiety episodes, then ask about medical history evidence, etc., to confirm the diagnosis. SCID helps ensure that other anxiety diagnoses are considered and excluded properly. However, SCID requires the clinician to integrate medical data (which might come from the patient's records or physicians) to decide if criterion B (medical cause) is met. **Mini-International Neuropsychiatric Interview (MINI):** This is a shorter structured interview. It has modules for mood and anxiety disorders, including a question like "Do you have panic attacks or anxiety that started after a serious medical illness?" and further questions if yes. The MINI can flag the possibility of a medical cause which then needs confirmation by medical evaluation. **Medical history & ROS (Review of Systems):** Because of the nature of this disorder, the structured psychiatric interview must be paired with a thorough medical review. Clinicians often use a checklist for medical symptoms (ROS) to uncover undiagnosed conditions. E.g., structured questioning about endocrine, cardiac, neurological symptoms is done. Some clinicians use forms or questionnaires that cover these (like "Have you had any weight loss, tremors, palpitations, etc."). The combination of psychiatric interview and medical review is essentially a *structured approach* to ensure nothing is missed. **Collateral interviews:** It's common to gather information from other treating physicians or family (with consent). For instance, a structured approach might involve contacting the patient's primary care doctor to confirm the timeline of the illness vs anxiety onset, or using a structured checklist for possible causes (like the "THINC MED" mnemonic) during evaluation [58] [37] . In practice, a psychiatrist or psychologist will use a standard structured diagnostic interview to identify that the patient has an anxiety syndrome, and concurrently a structured medical evaluation is either done or referenced. Many clinics have developed **protocols** (not formal published interviews) for new-onset anxiety: e.g., always do thyroid tests, etc., which is a semi-structured approach to ruling out causes. **Bottom line:** Structured diagnostic interviews help confirm the presence of an anxiety disorder and rule out primary anxiety diagnoses, but the clincher for this diagnosis is evidence of a medical condition – obtained via structured medical assessment rather than a psychiatric interview question alone.

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Self-Report Measures	Patients can complete various self-report questionnaires to quantify their anxiety and aid in diagnosis, although no self-report can on its own determine the cause of anxiety. Useful measures include: **GAD-7 (Generalized Anxiety Disorder-7):** A 7-item questionnaire used widely to screen for anxiety severity. It asks about nervousness, uncontrollable worry, restlessness, etc., over the last 2 weeks. Patients with this disorder often score high on GAD-7 when symptomatic. It's a quick tool that can alert clinicians to clinically significant anxiety (score ≥10) that warrants further evaluation [59] . **Beck Anxiety Inventory (BAI):** A 21-item inventory focusing on somatic symptoms of anxiety (e.g., numbness, sweating, etc.). It's very pertinent here because patients often have many physical anxiety symptoms. A high BAI score (which heavily weights autonomic symptoms) might reflect the physiological anxiety. Sometimes it can even help differentiate – if someone scores high on all physical items but not on worry items, it underscores the somatic nature of their anxiety, possibly clueing the clinician to look for a physical cause. **Hospital Anxiety and Depression Scale (HADS):** This is useful in medical settings. It has an Anxiety subscale (HADS-A) that avoids physical symptom items (to prevent confounding with medical issues) and focuses on anxiety mood and tension. It can be administered to track anxiety in medically ill patients without over-weighting somatic complaints. It's often used in hospitals to see if someone with, say, cardiac disease has significant anxiety requiring attention. **Anxiety Sensitivity Index (ASI):** A specialized self-report measure that assesses fear of anxiety sensations. Patients with high ASI have a strong fear that symptoms (like palpitations or dizziness) will have harmful consequences. If someone has a high ASI, they're more prone to panic when they feel physical symptoms [55] . This can be a useful measure to identify those who need more cognitive intervention to reframe the meaning of sensations. **Stress and coping inventories:** Though not specific to anxiety, tools like the Perceived Stress Scale (PSS) or Coping Strategy Inventory can give context – indicating if the patient perceives high stress or tends to use maladaptive coping (like denial or substance use), which could inform treatment focus. These self-reports **do not diagnose** "due to another medical condition" by themselves, but they provide a baseline of anxiety severity and some symptom profile. They are easily repeatable, so they can track improvement as treatment proceeds (e.g., GAD-7 dropping from 15 to 5 after treating hyperthyroidism and starting therapy). Additionally, a lack of response to anxiety self-report improvement despite medical stabilization might prompt re-evaluation for any primary anxiety component.

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Clinician-Rated Scales	Clinicians may use formal rating scales to objectively measure the patient's anxiety severity and track changes. Common clinician-rated tools: **Hamilton Anxiety Rating Scale (HAM-A):** A 14-item clinician-rated scale that assesses both psychic anxiety (anxious mood, fears) and somatic anxiety (physical symptoms). The clinician interviews the patient and then rates each item. A patient with this disorder might have high somatic item scores (e.g., cardiovascular, respiratory, GI symptoms) as well as psychic tension. HAM-A provides a total score (mild <18, moderate 18–24, severe >25). It's useful to document initial severity and monitor response to treatment [60] . For example, a HAM-A could drop significantly after the medical condition is treated, validating the effectiveness. **Clinical Global Impression (CGI):** Although very general, a clinician can use CGI-Severity (CGI-S) to rate how ill the patient is with anxiety at baseline (on a 1–7 scale), and CGI-Improvement (CGI-I) to rate change over time. This gives a snapshot of clinician judgement. For instance, "CGI-S = 5 (markedly ill) at intake, and CGI-I = 2 (much improved) after 8 weeks of treatment." **Structured Interview Guide for the Hamilton Anxiety Scale (SIGH-A):** A structured version of the HAM-A interview to improve reliability. It ensures the clinician asks specific questions for each HAM-A item. This can be helpful in research or in ensuring consistency if multiple clinicians are involved. **Panic Disorder Severity Scale (PDSS):** If panic attacks are the main feature, a clinician might use the PDSS (even if technically the panic is secondary) to quantify frequency and distress of panic attacks. It's a way to track that aspect specifically. Similarly, if OCD-like symptoms are present, the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) might be used. These specific scales focus on symptom subtypes relevant to the patient's presentation. **Observational checklists:** In hospital settings, sometimes nurses or doctors use observation charts (e.g., rating anxiety signs each shift). Not formal, but a way clinicians rate patient's visible anxiety (restlessness, etc.) in a more structured manner in general medical wards. Clinician-rated scales are valuable because they provide an objective measure that doesn't rely solely on patient self-report (which can sometimes be influenced by personality or under-reporting). For example, a patient might downplay symptoms in self-report but the clinician notes clear signs of anxiety and rates accordingly. Using these scales, especially HAM-A, can help in multi-disciplinary teams (everyone can see the score trends). Also, some insurance or protocols require such scales to measure outcome. In sum, while not specific to etiology, these scales quantify the **severity and improvement** of the anxiety, which is crucial to managing the disorder effectively.

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Psychometric Tools	Beyond symptom severity scales, there are other assessments that can be relevant: **Neuropsychological testing:** If the medical condition involves the brain (like a TBI or early dementia) and anxiety is part of the picture, formal cognitive testing may be done to differentiate what cognitive deficits exist and how anxiety might be affecting cognition. This isn't for diagnosing the anxiety, but to fully assess the patient's functioning. For instance, anxiety can impair memory; testing can clarify if memory issues are due to anxiety vs. neurological damage. **Personality assessments:** Tools like the NEO-PI or MMPI-2 might be used in complex cases to understand personality structure. The MMPI-2 has scales for health anxiety and neuroticism – a very high health anxiety scale might indicate the patient also has a hypochondriacal tendency apart from the organic cause. Personality info can guide how to approach therapy. However, these are not routine unless there's diagnostic ambiguity or treatment resistance. **Anxiety sensitivity and behavioral tests:** We mentioned the Anxiety Sensitivity Index (ASI) as a self-report. In a more experimental or therapeutic context, some clinicians do **behavioral tests** – for example, an interoceptive exposure assessment (having patient breathe fast to see if it triggers anxiety) to gauge their sensitivity to bodily sensations. High sensitivity suggests they might benefit from interoceptive exposure therapy. It's not a formal "psychometric" test with norms, but a clinical test of symptom provocation. **Quality of life and functional assessments:** Instruments like the SF-36 or WHOQOL can measure how much the anxiety (and illness) is impacting life overall. This is psychometric in the sense of giving a score for functional domains. It helps ensure we capture the broader impact, which can be important for documenting improvement (e.g., quality of life score improves as anxiety is treated). Similarly, the Sheehan Disability Scale (SDS) can quantify impairment in work, social, and family life due to anxiety – if scores drop with treatment, that's a positive outcome indicator. **Projective tests:** Rarely indicated here, but if there's diagnostic uncertainty or comorbid complex psychological issues, tests like the Rorschach or TAT could hypothetically reveal underlying emotional conflicts. Generally, though, in a clearly organic anxiety, projectives are not used, as the cause is physiologic rather than psychodynamic conflicts. They'd be used only if someone suspects coexistent psychological trauma or personality disorder fueling the anxiety beyond the medical trigger. Most critical are the **symptom-specific measures** and **functional assessments**. The ultimate "test" for this disorder is arguably a trial of treating the medical cause and seeing resolution of anxiety – a sort of empirical confirmation. Psychometric tools help monitor and guide treatment but identification still relies on clinical correlation of medical data with anxiety presentation.

Observation Methods	Direct observation by clinicians and family provides insight that supplements patient reports: **Clinical observation:** A healthcare provider might observe the patient during an anxiety episode. For example, in a hospital, nurses might note that a patient becomes visibly anxious (wringing hands, rapid breathing) whenever their blood sugar drops below a certain level – correlating anxiety with a medical event. Observing that anxiety *follows* medical symptom onset (like pain, arrhythmia, etc.) strengthens the case for causality. Clinicians also look for signs such as impaired attention or disorientation which would suggest delirium instead [61] ; their absence during anxiety episodes supports that it's an isolated anxiety syndrome, not delirium. **Mental status exam (MSE):** On MSE, typical observations include: anxious mood/affect (patient appears tense, worried), psychomotor agitation (fidgety, pacing), maybe sweaty palms or shakiness. Importantly, orientation and cognition are intact (helping rule out delirium as noted). If the patient is seen at rest vs after a trigger, one might observe a dramatic change – e.g., calm when lying in bed, then an IV infusion starts (medical trigger) and suddenly the patient is trembling and panicky. That temporal relationship on observation is very telling. **Behavioral avoidance observation:** A therapist or doctor might conduct an in vivo observation of behavior. For instance, if a patient avoids walking due to fear of palpitations, a clinician might gradually walk with them in a controlled setting and observe at what point anxiety spikes. This not only confirms the behavior but can be part of exposure therapy. Similarly, observing how a patient performs breathing exercises can show if hyperventilation is voluntary or anxiety-driven. **Family reports:** Family members often provide valuable observations. They might say, "I notice she wakes up in a panic around 3 AM every night" or "When he gets anxious, his face turns red and he starts pacing until he checks his blood pressure." These descriptions help pinpoint triggers and symptoms. Family might also note improvement: "Ever since the pacemaker was placed, I haven't seen him have those anxiety spells," which is an observational clue that treatment worked. **Video or remote monitoring:** In some cases (like epilepsy vs anxiety differentiation), video EEG monitoring is used – not typical for this disorder unless there's diagnostic doubt (e.g., panic attacks vs temporal lobe seizures). But one could consider that a form of observation method. More practically, a patient might keep a diary or even record themselves (some use smartphone apps to track symptoms). That observational data can reveal patterns (e.g., anxiety happens every afternoon – which might coincide with medication wearing off or steroid dosing times, etc.). In essence, careful observation can discern **pattern and context**: anxiety symptoms that correlate strongly with medical events or changes (like "whenever oxygen drops, he panics"), absence of anxiety in safe contexts, presence of physiological signs, etc. Observation also helps differentiate volitional behavior from involuntary (to address any concerns of somatic symptom disorder exaggeration – in this condition the anxiety signs are genuine and often reproducible with the medical trigger). Observational evidence is often what initially raises suspicion of a medical cause (e.g., clinician notices "these panic attacks have unusual features like confusion or occur alongside abnormal vital signs – let's investigate further").

Lab / Neuroimaging Considerations	**Medical investigations are key** to identifying and confirming the underlying condition. The work-up is guided by clinical suspicion but often includes: **Laboratory tests:** A broad lab panel is common. For example, **thyroid function tests (T3, T4, TSH)** are almost routine in new-onset anxiety to check for hyperthyroidism [62] . **Glucose levels** (fasting or during symptoms) to detect hypoglycemia. **Electrolytes and metabolic panel** (to find issues like hypercalcemia or adrenal problems). **Complete blood count (CBC)** (e.g., to see if anemia might cause palpitations and anxiety, or infection markers). If pheochromocytoma is suspected, **plasma free metanephrines or 24h urine catecholamines** would be done. If Cushing's is on the differential, **cortisol levels or dexamethasone suppression test**. In specific cases, **B12 levels** (for B12 deficiency), **toxicology screen** (to rule out stimulants), or **autoimmune panels** (if autoimmune encephalitis is possible) might be done. The key is that appropriate labs can *confirm* the medical cause – e.g., a very low TSH and high T4 confirms thyrotoxicosis in someone with anxiety. **Cardiac evaluation:** Since cardiac symptoms are common, **ECG** is often part of the work-up (to catch arrhythmias like atrial fibrillation or SVT that might cause anxiety episodes) [63] . If palpitations or chest pain are present, doctors might do an **echocardiogram** or **Holter monitor** to see if structural heart disease or rhythm disturbances are underlying. A positive finding (say runs of SVT coinciding with panic) would direct treatment to fixing the arrhythmia. **Neuroimaging: Brain MRI or CT scan** may be warranted if neurological symptoms exist (headaches, seizures, focal deficits) or if no peripheral cause is found. We look for tumors (especially in places like adrenal or CNS), evidence of stroke, MS lesions, etc. For example, an MRI might reveal a small meningioma pressing on limbic areas causing anxiety, or a subtle encephalitis. If panic starts in late life, an MRI can rule out strokes or degenerative changes. **EEG** could be done if non-epileptic vs epileptic panic is in question. Usually imaging is guided by specifics (e.g., new neurological signs or atypical course). **Specific exams:** Depending on context, **pulmonary function tests** (for unexplained dyspnea/panic to see if asthma is there), **vestibular testing** (if dizziness is prominent – maybe it's an inner ear issue causing anxiety), or **toxin screens** (heavy metals, etc.) might be done. For instance, Lyme disease test if there's exposure history and anxiety + neurological oddities. The *THINC MED* mnemonic in practice means: check for Tumors, Hormones, Infections, Nutrition, CNS, Misc (chronic diseases), Electrolytes, Drugs [58] [37] [56] – each of those implies certain lab or imaging tests, such as scanning for adrenal tumor, hormone assays, infectious serologies, vitamin levels, etc. **Monitoring and correlation:** Sometimes it's useful to capture data during an anxiety episode. For example, if the patient reports episodic anxiety, having them wear a **Holter monitor** or a **continuous glucose monitor** might catch an abnormality concurrent with anxiety onset (like a spike in heart rate or drop in glucose). In hospital, nurses might note vital sign changes during panic (tachycardia, hyperventilation with low CO_2 on blood gas, etc.). These objective measures strengthen the link between physiology and anxiety episodes. In summary, a thorough medical workup is *integral* to this diagnosis – it's often how the cause is found. Many patients will already have had some labs done by primary care or ER before they reach psychiatry. If

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	not, a psychiatrist will recommend such evaluation [62]. One cannot assign this diagnosis without evidence of a medical condition, and labs/imaging provide that evidence. Repeating or tracking labs can also gauge improvement (e.g., as thyroid levels normalize, one expects anxiety to improve). Additionally, ongoing monitoring might be needed (e.g., periodic cortisol checks in an adrenal disorder) to preempt relapses of anxiety. Neuroimaging is not needed for every case, but it's important in cases with any suggestion that central pathology could be at play or if no other cause is apparent. All in all, the **"medical detective" work** via lab and imaging is what sets this diagnosis apart from purely psychiatric diagnoses.

First-Line Pharmacological Treatments	The primary approach is to **treat the underlying medical condition**, as that often leads to resolution of anxiety. However, to manage anxiety symptoms, first-line psychiatric medications mirror those for primary anxiety: **Selective Serotonin Reuptake Inhibitors (SSRIs):** SSRIs (such as **sertraline, escitalopram, paroxetine, fluoxetine, citalopram**) are often used as first-line long-term medications for anxiety disorders, including this one [64] [65] . They help by modulating serotonin in the brain's anxiety circuits. For instance, if a patient's hyperthyroidism is being treated but they still have anxiety, starting an SSRI can reduce persistent anxious feelings. SSRIs usually take a few weeks to show effect; improvement in anxiety might be seen after ~4 weeks, with full effect by 6-12 weeks [66] . Often a **low starting dose** is used and titrated up to avoid initial jitteriness (SSRIs can transiently increase anxiety at first in some patients). SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors like **venlafaxine, duloxetine**) are similarly first-line, particularly if patients have concomitant pain or depression; venlafaxine is effective for generalized anxiety [67] . **Benzodiazepines:** Rapid relief can be obtained with benzodiazepines (e.g., **alprazolam, lorazepam, clonazepam**), which enhance GABA and quickly calm anxiety [68] . These are particularly useful if the patient is having acute panic attacks or extreme anxiety while waiting for medical treatment or SSRI to take effect. For example, a patient with pheochromocytoma awaiting surgery might be given a low-dose benzodiazepine to smooth out anxiety surges. However, benzos are typically short-term or PRN (as needed) due to risks of sedation, tolerance, and dependence. Clonazepam or lorazepam might be chosen for longer half-life and smoother effect, whereas alprazolam is shorter-acting for acute episodes. Caution: if the patient has respiratory issues (COPD) or is elderly, benzos must be used carefully to avoid respiratory depression or falls. **Beta-Blockers:** Non-selective beta-blockers like **propranolol** can help control the peripheral physical symptoms (tremors, palpitations) of anxiety [68] . They're particularly helpful if episodes are situational (like anxiety spikes with certain activities) or while underlying causes (like hyperthyroid) are being corrected. Propranolol is often used in hyperthyroid patients anyway to manage tachycardia, and it conveniently blunts anxiety symptoms too. Beta-blockers don't directly affect worry in the mind, but by reducing somatic sensations, they can indirectly alleviate some anxiety. Typical dosing might be propranolol 10-40 mg a few times daily. They are first-line specifically in scenarios like **thyroid-related anxiety** or **performance situations**. Caution if the patient has hypotension or asthma (beta-2 blockade can worsen asthma). **Treating the cause pharmacologically:** It must be emphasized that *first-line* also includes the direct medical treatments: e.g., **antithyroid drugs (Methimazole/PTU)** for hyperthyroidism, **insulin or dietary management** for hypoglycemia/diabetes, **bronchodilators and steroids** for severe asthma causing panic from dyspnea, etc. These are not psychiatric meds, but they are first-line in the sense that without controlling the cause, no amount of psychiatric medication will fully quell the anxiety. So, coordination with the appropriate specialist to ensure the patient is on optimal medical therapy (or surgical interventions if needed, like adrenalectomy for pheochromocytoma) is part of "treatment." In many cases,

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	once the cause is addressed, heavy use of psychiatric meds may not be needed long-term. In summary, **SSRIs/SNRIs for long-term management** and **benzodiazepines for short-term or situational relief** are the main psychotropic treatments, analogous to treating any anxiety disorder [64] [68]. Beta-blockers serve as an adjunct particularly for somatic symptom control. The ideal scenario is treating the source (e.g., correcting a hormone imbalance) and using these medications to keep the patient comfortable and functional until (and after) that is achieved. All medications are chosen in consideration of the patient's medical status (for instance, if they have liver disease, one picks medications metabolized safely; if they have heart block, avoid high-dose beta-blockers, etc.).

Alternative Pharmacological Options

If first-line treatments are inadequate or not well-tolerated, several alternative or adjunctive medications can be considered: **Buspirone:** A non-benzodiazepine anxiolytic that works as a serotonin 5-HT1A partial agonist. **Buspirone** is particularly useful for chronic worry (generalized anxiety) and has no sedative or dependency issues. It's an option if SSRIs are not tolerated or contraindicated, or as an add-on for residual anxiety [69] . Buspirone takes a couple weeks to start working and is usually dosed 2-3 times daily. It might be chosen for someone with, say, mild persistent anxiety after partial medical treatment, especially if they have a history of substance misuse (since buspirone is non-addictive).
Tricyclic Antidepressants (TCAs): Medications like **imipramine** and **clomipramine** are older antidepressants with anxiolytic properties. Imipramine has evidence in panic disorder; clomipramine is very effective for OCD. They might be used if SSRIs fail or if there's a coexisting condition like OCD (clomipramine could treat both). In this context, for example, if a patient has anxiety due to a medical condition and also significant obsessive worry, clomipramine might help. TCAs have more side effects (anticholinergic, cardiac) so one must be cautious especially as many patients are older or have medical comorbidities. For instance, in someone with arrhythmia, a TCA could worsen conduction, so SSRIs are preferable [67] . But TCAs remain an alternative for refractory cases.
Beta-blocker alternatives: If propranolol isn't tolerated (say due to asthma), **benzodiazepines** can cover some of that ground, or one might try **clonidine** (an alpha-2 agonist) which can reduce sympathetic outflow. Clonidine can help with the jitteriness and is sometimes used in withdrawal-related anxiety; its use here is less common but conceivable if high sympathetic tone is an issue and beta-blockers can't be used.
Hydroxyzine: An antihistamine with anxiolytic effects (often used as needed for mild anxiety or when benzos must be avoided, such as during pregnancy). Hydroxyzine can cause sedation but no dependency, so it's an alternative PRN option. For example, an anxious patient with a heart condition who cannot take benzos might use hydroxyzine for short-term relief.
Atypical antipsychotics: Generally not first or second-line for pure anxiety, but occasionally a low dose of an atypical antipsychotic (like **quetiapine**) is used off-label for severe anxiety or if there are co-occurring issues like nausea (it has antiemetic and sedative properties) or if the patient has some paranoid fears about their illness that border on delusional. This is rare and usually reserved for treatment-resistant cases or when other routes fail. One must weigh metabolic side effects which could impact the medical illness.
Gabapentinoids: Pregabalin or **gabapentin** have anxiolytic effects and are sometimes used in generalized anxiety or in patients with chronic pain conditions (e.g., fibromyalgia). If a patient's anxiety is entwined with neuropathic pain or fibromyalgia (which itself can cause anxiety), pregabalin could address both [70] . Pregabalin has evidence in GAD as well. These are renal-excreted, so relatively safe for liver, but can cause dizziness or edema.
Beta-agonists for some cases: Interestingly, if the cause is something like adrenal insufficiency (Addison's disease), they might need *hormone replacement* which resolves anxiety. Not "alternative" per se, but pointing out that sometimes the "medication" is directly treating the deficiency

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	(like fludrocortisone, hydrocortisone in Addison's). Similarly, if anxiety due to severe anemia, the "treatment" might be iron or transfusion rather than psych drugs. Often, these alternatives are used in combination. For example, an SSRI might be combined with buspirone (this combination is known to be synergistic in some anxiety cases). Or a patient might be on a medium-dose SSRI plus low-dose clonazepam at night for persistent anxiety and sleep aid. The regimen is highly individualized to the patient's needs and medical profile. Importantly, any medication has to be cross-checked with the patient's medical condition and other meds for interactions. (E.g., if the patient's on a beta-agonist inhaler for asthma, adding propranolol might not be ideal – but one might still carefully use a selective beta-1 blocker if needed). **Summary:** Alternatives like buspirone and TCAs provide options when first-lines fail, and adjuncts like hydroxyzine or gabapentin can target specific symptom domains. The overarching principle is to alleviate anxiety without exacerbating the medical condition or introducing excessive side effect burden.

Medication Side Effects	**Side effect management** is crucial, given patients already have medical issues. Common considerations: **SSRIs/SNRIs:** These can cause *transient increased anxiety or jitteriness* in the first week or two [71] – to counteract, start low and titrate slowly. Other side effects: **nausea, gastrointestinal upset**, which can be troublesome if the patient has a GI condition, but usually mild and improving in a few days [72] [71] . **Insomnia or somnolence** – some feel restless and can't sleep (dose in morning if so), others feel fatigued. **Sexual side effects** (decreased libido, delayed orgasm) are common with SSRIs and should be mentioned, as they can affect adherence. *Worsened anxiety initially* was noted: e.g., some patients report feeling "on edge" or more panicky in week 1 – in such cases, dose reduction or temporary benzo cover can help [73] . SNRIs can also raise blood pressure slightly due to norepinephrine reuptake, so monitor BP – relevant if the patient has hypertension or cardiac issues. **Benzodiazepines:** Main side effects: **sedation, drowsiness, fatigue**, which can impair activities (no driving if feeling sedated). **Cognitive slowing or confusion** – especially in older adults, benzos can cause memory issues or delirium-like states. **Risk of falls** in elderly (due to ataxia, especially with longer-acting or higher doses). Respiratory depression is a concern if combined with other depressants or if the patient has COPD or OSA. Thus, in someone with severe COPD who already is low on oxygen, benzos must be used sparingly if at all. There's also **dependency/tolerance**: prolonged use can cause the body to adapt, requiring higher doses and causing withdrawal if stopped suddenly. For that reason, they're usually short-term. If a patient has a history of substance abuse, benzos carry risk of misuse – might choose alternatives in that case. Benzos can also *paradoxically* disinhibit or cause agitation in a small subset (idiosyncratic reaction). **Beta-Blockers:** These can cause **bradycardia (slow heart rate)** and **hypotension**. Patients might feel *lightheaded or fatigued* from a lowered heart rate and blood pressure. They can also cause *cold extremities* or mild **exercise intolerance** (since heart rate can't rise as much). In asthmatics or COPD, non-selective beta-blockers can precipitate **bronchospasm** (wheezing, shortness of breath) because of beta-2 blockade – so one must be careful or use a selective beta-1 blocker if absolutely needed. They can also contribute to **depression or sexual dysfunction** in some cases (though those are more chronic side effects). Patients should be counseled not to abruptly stop beta-blockers either, as rebound tachycardia can occur. **Buspirone:** Generally well-tolerated. Can cause **dizziness, headache, nausea** in some. No sedation typically, but a slight risk of agitation if dose is started too high. It does not cause dependency. Some patients report *restlessness or insomnia* initially, but usually it's pretty benign. It doesn't have sexual side effects like SSRIs. **TCAs:** Have a significant side effect profile: **anticholinergic effects** (dry mouth, constipation, urinary retention, blurred vision), **sedation**, **weight gain**, and potential **cardiac arrhythmias or conduction prolongation** (they can lengthen QT interval). In overdose, they are cardiotoxic – something to consider if the patient is at any suicide risk (less likely if anxiety is purely due to a medical condition and not depression, but caution). Because many patients with medical conditions are older, TCAs' anticholinergic effects can cause confusion or exacerbate conditions like BPH or glaucoma. So if used, often need EKG

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	monitoring and going slow. **Others:** Hydroxyzine causes **drowsiness** (antihistamine effect) and dry mouth. Atypical antipsychotics like quetiapine can cause **metabolic side effects** (weight gain, glucose increase) which might interfere with conditions like diabetes. They also cause sedation. Gabapentin/ pregabalin cause **dizziness, somnolence, edema**. Clonidine can cause **low blood pressure and fatigue**. Importantly, because these patients have other medical treatments, one must watch for **drug interactions**: e.g., if the patient is on warfarin, SSRIs can potentiate bleeding risk; if on other sedatives or opioids, benzodiazepines compound CNS depression; some beta-blockers with certain asthma meds can have issues, etc. Also, **monitoring** is often indicated when starting meds: for instance, checking blood pressure a week after starting an SNRI if the patient has hypertension, or doing an EKG before titrating a TCA in someone with heart disease. **Patient education** about side effects is vital: they should know SSRIs may cause transient anxiety worsening or GI upset [73], that benzos can impair driving, etc. This helps ensure adherence and no surprises. In general, we try to use the lowest effective doses to minimize side effects. If side effects are troublesome, switching class is considered (e.g., SSRI causing sexual dysfunction – maybe switch to buspirone augmentation or another class). The goal is to find a regimen that the patient tolerates well given their overall health.

Medication Monitoring Requirements	Given these patients often have complex health, **monitoring is important** for both efficacy and safety: **Follow-up timeline:** Initially, follow-up might be frequent (every 1-2 weeks) to check on medication tolerability and symptom change [66]. SSRIs: monitor at ~4 weeks for first signs of improvement; if none, consider dose increase. Benzos: if used, monitor usage frequency to watch for increasing use or dependence signs. Engage in routine check-ins for side effect emergence (e.g., ask about sleep, appetite, dizziness, etc.). Many providers will schedule a 1-week phone call after starting an SSRI to make sure side effects aren't too bad and patient isn't more anxious. **Laboratory monitoring:** Some medications require labs. For instance, if a patient is on a TCA, a **plasma level** could be checked for safety (especially nortriptyline or imipramine levels if near high end dose). If on lithium (not common in this scenario, but if mood symptoms co-occur), lithium levels and kidney/thyroid tests are needed. For SSRIs, usually no routine lab needed, but if the patient has other meds or hepatic issues, periodic liver function tests might be prudent (SSRIs metabolize in liver). Benzos don't require labs, but in long term use, maybe LFTs if high dose for years. For patients on multiple meds, occasionally monitoring electrolytes or ECG if something like citalopram at high dose (can prolong QT in rare cases) is done. **Vital signs:** When starting or adjusting **beta-blockers**, monitor blood pressure and pulse (e.g., come in after a week for a BP/pulse check). With **clonidine**, monitor BP. With SNRIs, maybe check BP after some weeks. If the medical condition itself demands monitoring (e.g., thyroid levels, glucose logs), that should continue – often improvement in those correlates with improvement in anxiety. **Mental status and suicide risk:** Even though this is a secondary anxiety, part of monitoring is always checking the patient's mental status and any emergence of depressive or suicidal thoughts (particularly if starting an SSRI, there's a small risk of activation or suicidal ideation in young adults). As noted earlier, severe anxiety can sometimes push suicidal ideation [74], so it's something to track at each visit ("How's your mood? Any thoughts of harming yourself because of all this?"). If any depression is noted, adjust treatment accordingly (maybe add therapy or antidepressant dose change). **Medication adherence:** Sometimes people reduce or stop meds when they feel better (especially if the medical cause is fixed, they might think "I don't need the SSRI anymore"). So monitor adherence and if they want to discontinue, do it properly (taper SSRIs/benzos rather than abrupt stop to avoid withdrawal or rebound). Encourage continuation for an adequate period (often we say at least 6-12 months for SSRIs after response) to prevent relapse unless the medical cause is 100% cured and no residual anxiety. **Drug levels and interactions:** If the patient adds any new meds, check interactions. Eg, if they start a new cardiac med, ensure it doesn't interact with their psych meds. If an SSRI is raising levels of other drugs (like warfarin or antiarrhythmics via CYP interactions), relevant blood levels or clinical monitoring should be done. If benzodiazepines are used long-term, consider periodically trying to taper to see if still needed, under supervision. Many clinicians will create a **monitoring plan**: e.g., patient will log anxiety episodes and triggers, monitor pulse when anxious, bring that diary to appointments. Also a plan for the medical side: ensure they follow up with internist or endocrinologist to

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	monitor the primary illness (like thyroid levels every few weeks until stable, etc.). This coordination is part of monitoring since if the medical illness relapses, anxiety likely will too. In short, monitoring involves a combination of **symptom tracking**, **side effect surveillance**, and **medical follow-through**. Because these patients often see multiple providers (primary care, specialists, psychiatry), communication and shared monitoring is beneficial. For instance, a psychiatrist might ask the primary doctor to forward thyroid labs or blood pressure logs so they can incorporate that into the anxiety management plan.

Recommended Psychotherapy Modalities

Psychotherapy is a key component alongside medical treatment. The most recommended modalities are those effective for anxiety in general, tailored to include the medical aspect: **Cognitive-Behavioral Therapy (CBT):** This is considered the gold-standard therapy for anxiety disorders and is equally applicable here [75] . CBT focuses on identifying and modifying the *negative thought patterns* (e.g., catastrophic thinking about symptoms) and gradually reducing avoidance behaviors. A core element for panic symptoms is **interoceptive exposure** – the therapist might help the patient simulate symptoms (like spinning in a chair to create dizziness) and then practice tolerating that sensation without panicking, to break the fear of bodily symptoms. Another element is **cognitive restructuring**: e.g., if a patient thinks "When I feel my heart race, I'll collapse," CBT works to challenge that belief ("You've felt this many times and you're still here; it's your thyroid causing adrenaline rushes which are not actually dangerous") [75] . Over ~10-12 weekly sessions (typical length, though it varies) [76] , patients often experience significant reduction in anxiety. CBT may also incorporate relaxation training or breathing techniques as needed. It is often the **therapy of choice** because it's short-term, skills-oriented, and has evidence of lasting benefits beyond the end of therapy [77] . It can be done individually or in group format (group CBT might be possible if multiple patients have health-related anxiety).
Psychoeducation: While not a formal "modality," educating the patient about the link between their medical condition and anxiety is therapeutic. Many protocols include an early session entirely devoted to explaining the mind-body connection and normalizing their experiences ("these symptoms are a known effect of your condition, you're not alone") [23] . This often alleviates a lot of fear of the unknown and empowers the patient to engage in treatment. Family can be included in psychoeducation sessions as well.
Relaxation techniques and stress management: Modalities like **Progressive Muscle Relaxation (PMR)**, **deep breathing exercises**, or **biofeedback** can help reduce the physiological arousal. Some therapists integrate these techniques within CBT or do standalone relaxation training. **Biofeedback** (where patients learn to control physiological measures like heart rate or muscle tension with feedback from instruments) can be particularly helpful for patients who have prominent physiological triggers – it gives a sense of control over body responses. These approaches help manage acute symptoms and complement cognitive strategies [57] .
Mindfulness-Based Therapies: Mindfulness-Based Stress Reduction (MBSR) and mindfulness-based cognitive therapy teach patients to non-judgmentally observe their sensations and thoughts rather than panicking about them. This can be powerful for someone who has recurrent physical symptoms – they learn to experience, say, a palpitation as just a sensation, not a catastrophe. Mindfulness has evidence for reducing anxiety and can be taught in 8-week group formats or integrated into individual therapy sessions. It also helps with any chronic pain or stress from the medical condition.
Supportive Therapy: Sometimes a patient mostly needs a space to vent fears and get emotional support. A supportive counseling approach can reinforce that their reactions are understandable and help bolster their coping resources. The therapist uses reassurance (appropriately, based on medical

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	info), problem-solving, and encouragement. This can be continuous or intermittent. While not as structured as CBT, it's beneficial if the patient is too overwhelmed to engage in CBT initially or if they have a lot of emotional adjustments to make (like dealing with a new chronic illness diagnosis). **Acceptance and Commitment Therapy (ACT):** ACT is a newer modality that encourages accepting what is out of one's control (e.g., having this medical condition) and committing to actions that improve life (aligning with values, despite anxiety). ACT techniques, such as cognitive defusion (viewing thoughts simply as thoughts, not truths) and mindfulness, can help patients not be dominated by the anxiety. For example, ACT might help a patient say: "I acknowledge I feel anxious sensations; I don't like them, but I can still live my life and do what I value rather than shrinking away." This approach can reduce the struggle against anxiety and improve functioning even if some anxiety is present. Often a **combination** of these is used. For instance, a typical treatment plan: psychoeducation + CBT with some relaxation training incorporated. In complex cases, psychotherapy might also address **coping with the medical illness itself** – sometimes blending elements of health psychology (like how to manage the demands of diabetes or heart disease) with anxiety management. If the patient's life is significantly altered by the illness (loss of job, etc.), therapy might also include elements of **adjustment counseling** and grief processing for the lost sense of health. **Group therapy or support groups** can also supplement formal psychotherapy, giving patients a forum to share experiences and coping tips. But the evidence-based modality for symptom reduction is CBT, so that's usually recommended as the first-line psychotherapy.

Core Therapeutic Goals	In psychotherapy and overall treatment, the **primary goals** are: **Reduce anxiety severity and frequency:** The immediate aim is to alleviate the patient's distressing anxiety symptoms to a manageable level. That means fewer panic attacks, less constant worry, better sleep, and improved calmness day-to-day. Achieving symptom reduction improves quality of life and allows the patient to focus on other aspects of recovery. **Address the physiological cause:** A crucial goal (usually undertaken by medical treatment) is removing or mitigating the trigger. In therapy, the goal is to ensure the patient adheres to medical treatments that will resolve their anxiety (e.g., consistently taking thyroid meds or going through with a recommended surgery). Psychologically, we support them through those treatments (reducing fear of procedures, etc.). So, one goal can be phrased as **"successful management of the underlying condition"** – even though it's medical, the therapist reinforces it (like building motivation to stick with a perhaps unpleasant treatment regimen because it will help their anxiety). **Improve functional ability:** Anxiety often disables patients from fully living their life. A core goal is to help them resume normal activities – whether returning to work, socializing, exercising, or pursuing hobbies. For instance, if they stopped driving due to panic attacks, a goal is to get them driving again (via gradual exposure in therapy). We measure success partly by these functional milestones: can they do what they need and want to do without undue anxiety? **Eliminate avoidance behaviors:** A specific goal is to identify any avoidance (of exercise, going out alone, etc.) and systematically reduce it. Overcoming avoidance restores independence and shrinks the hold anxiety has on the patient's life. Goals might include things like "patient will be able to take a 30-minute walk by themselves" or "will be able to sleep without checking blood pressure 10 times." **Develop effective coping strategies:** Equip the patient with a **toolkit for managing anxiety**. This includes cognitive strategies (like realistic self-talk when symptoms hit: "This is just my body reacting, I am not in grave danger" [75]), relaxation techniques (deep breathing, grounding exercises), and problem-solving skills for stress. The goal is for the patient to feel confident that they have ways to handle anxiety spikes rather than feeling helpless. **Enhance insight and confidence:** Another goal is more psychological – to get the patient to truly *believe* and internalize that the anxiety is not a sign of insanity or immediate death, but a treatable symptom of a treatable condition. As their understanding and mastery grows, their overall fear of fear diminishes. We often aim for that point where patients can say, "I know what to do when I start feeling anxious, and I know it will pass." **Prevent relapse and prepare for future:** Given that some medical conditions can relapse or life can present new challenges, a goal is to prepare the patient to maintain gains. This might involve setting up a maintenance plan (ongoing light exercise, continued practice of therapy techniques, regular medical check-ups). The goal is long-term management: the patient should be able to recognize early warning signs of anxiety returning and respond early, and to maintain lifestyle adjustments (like caffeine avoidance or good sleep hygiene) to keep anxiety at bay. All these goals revolve around two core outcomes: **reducing suffering** and **restoring/improving functioning**. In documentation, one might see goals like: "Patient will report a

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	50% reduction in panic attack frequency within 8 weeks" (specific symptom goal), or "Patient will resume attending church services (which she stopped due to anxiety) by end of therapy" (functional goal), or "Patient will demonstrate use of coping skills (e.g., breathing exercise) when feeling anxious (skills mastery goal)." The combination of medical and therapeutic intervention aims to not only remove the cause of anxiety but also empower the patient to live fully without being crippled by fear.

Therapist Role/ Approach	The therapist takes on multiple roles: **Educator:** Therapists provide clear education about how the medical condition leads to anxiety symptoms (the "mind-body" explanation) [23]. They dispel myths (e.g., "No, you're not losing your mind – this is a known effect of high thyroid hormone," or "Those chest pains are a muscle reaction to stress, not another heart attack, given your tests are normal"). By educating, the therapist helps the patient (and family) reattribute symptoms correctly, which already reduces panic about the unknown. They also instruct the patient in specific techniques (like how to do deep breathing, how to challenge a thought), effectively teaching skills in session and via homework. **Coach/Collaborator:** In CBT especially, the therapist acts like a coach – collaboratively setting up exercises (e.g., exposure tasks), encouraging the patient, and troubleshooting obstacles. For example, if a patient is afraid to walk around the block for exercise, the therapist might literally do it with them first or set up a gradual plan, offering encouragement and celebrating successes. The therapist works with the patient's feedback to adjust strategies (collaborative empiricism in CBT). There's often homework (like logging symptoms or practicing relaxation), and the therapist reviews it and guides improvements, much like a coach would with training drills. **Supportive listener:** The therapist also provides a safe space for the patient to express fears and frustrations. Some sessions might involve letting the patient vent about how scary an episode was or how life changes due to illness are affecting them. The therapist validates those feelings ("I hear how frightening that experience was for you") and provides emotional support. This rapport building and empathy can be therapeutic in itself, especially if patients feel others don't understand what they're going through. **Problem-solver:** Many times, managing anxiety in the context of medical issues requires practical problem solving. A therapist might help the patient figure out, say, how to structure their day to minimize anxiety (perhaps scheduling small, attainable activities, ensuring they don't skip meals to prevent hypoglycemia, etc.), or how to discuss their condition with their employer or family. If a patient is avoiding things, therapist helps break down the problem and find solutions to gradually re-engage. They might also help plan for medical appointments (like writing down questions for doctor) so the patient feels more in control – all of which reduces overall anxiety. **Liaison to medical team:** The therapist often collaborates with physicians. With consent, they might update the primary doctor that anxiety is improving or if they notice something medically concerning. Likewise, they may receive info from doctors on how the medical treatment is going. The therapist ensures psychological and medical interventions are in sync. For instance, timing therapy exposure exercises not in conflict with medical treatments (like not doing a heavy exposure on the day right after a chemo session when patient is physically unwell). Being a liaison ensures a unified approach – the patient sees that all providers are on the same team. **Monitor and motivator:** The therapist monitors progress, keeps track of symptom changes, and motivates the patient to continue. When setbacks occur (like an anxiety flare-up), the therapist helps the patient not to despair but to learn from it. They reinforce progress ("Look how far you've come – two months ago you wouldn't leave the house, now you travelled to the

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	store!"). They also may involve or educate family to assist in motivating and reinforcing healthy behaviors at home. Throughout, the therapist's approach is typically **empathic, reassuring, yet empowering**. They want the patient to feel heard and supported, but also to gain confidence in their own ability to handle symptoms. A pitfall to avoid is inadvertently reinforcing health anxiety – the therapist does not want to become just another source of reassurance for every symptom without helping the patient build self-reliance. Thus, the approach balances validation with encouraging the patient to use their learned skills. Over time, the therapist "fades out" as the patient's own coping increases. For instance, initially the patient might call the therapist in panic between sessions; later, with confidence, they use a skill and then just report in session how they handled it. The therapist's ultimate role is to **make themselves unnecessary** by equipping the patient to manage on their own.

Common Challenges in Treatment	Treating this disorder can encounter several hurdles: **Diagnostic ambiguity:** Early on, it might be unclear how much of the anxiety is due to the medical condition vs other factors. Some patients bounce between medical and psychiatric clinics because each side suspects the other ("Cardio says it's anxiety, psych says check cardio"). This can delay treatment. The challenge is to concurrently investigate medical causes while providing some symptomatic relief – basically treating in parallel. Overcoming this involves good interdisciplinary communication and sometimes proceeding with treatment even if some uncertainty remains (with close monitoring). **Patient reluctance to accept psychological help:** Some patients firmly believe "It's all physical – why are you sending me to a therapist or giving me an SSRI?" They may feel offended, thinking the doctor is dismissing their real illness as "in your head." This is a delicate challenge – requiring careful explanation that the therapy/medication is aimed at the real symptoms they're feeling and is *adjunct* to medical care, not implying it's imaginary. Emphasizing the medical cause while introducing psychiatric treatment as a way to relieve suffering usually helps. It often takes a bit of rapport and trust-building for patients to embrace therapy, especially if they've never seen a mental health professional before. **Managing medical fluctuations:** If the underlying condition isn't yet well-controlled, the patient may have unpredictable spikes of anxiety. This can make therapy feel like two steps forward, one step back. For example, you make progress, then the patient's lupus flares and their anxiety skyrockets again. This requires flexibility – the therapist might need to pause certain exposure work and shift to supportive mode during a flare, then resume once stable. It also can be demoralizing for the patient ("I was doing better and then bam, back to square one"). The therapist works to keep them motivated through these fluctuations. Coordination with the medical team to rapidly address flares (e.g., adjusting medical treatment) is also vital. **Medication interactions and side effects:** Because these patients may be on multiple meds (for their medical issue and anxiety), side effects or interactions can complicate treatment. For instance, an SSRI might elevate blood levels of a beta-blocker, causing too low blood pressure – requiring dose adjustments. Or the patient might attribute any new symptom to the psych med and want to quit it (e.g., experiencing normal transient SSRI nausea but fearing it's harming them). Overcoming this means careful med selection, starting low, and lots of patient education about expected side effects. Sometimes we switch strategies if side effects prove too troublesome (e.g., patient with COPD cannot tolerate propranolol, so we rely on more benzo/therapy instead). It's a bit of trial and error to find the right regimen balancing efficacy and tolerability. **Dependency or avoidance cycles:** If benzodiazepines are used, a challenge is preventing dependency or over-reliance. Patients might find benzos so helpful that they lean on them instead of using therapy skills – or start escalating doses on their own. Clear limits, close follow-up, and encouraging non-pharm techniques are needed. Similarly, patients might be very avoidant of triggers and reluctant to do exposures ("I really don't want to try exercise, I'm sure it'll trigger something"). It can be challenging to coax them out of this safety zone. The therapist often has to proceed slowly, build trust, and provide a lot of reassurance during exposure

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	exercises to surmount avoidance. Involving a physician to say "Medically, it's okay for you to do this activity" can sometimes persuade a hesitant patient to attempt it. **Psychiatric comorbidity:** If there is a co-occurring depression or personality disorder (say, underlying dependent or obsessive-compulsive personality traits), these can complicate treatment. Depression might sap motivation to do therapy homework. Personality factors could lead to resistance or interpersonal issues in therapy (e.g., an obsessive personality might excessively seek certainty and struggle with the uncertainty inherent in any medical condition). The therapist may need to address these comorbid issues directly in therapy (like doing some cognitive work on depressive thoughts, or adjusting communication style to suit an obsessive planner by providing more detailed explanations). In severe cases, additional treatments (like an antidepressant specifically for depression or more frequent therapy sessions) might be needed to manage these alongside the anxiety. **Social/environmental challenges:** If a patient's life circumstances are very challenging (e.g., no insurance to cover treatments, or a family that undermines therapy by saying "just snap out of it"), these external issues can hinder progress. Therapists often play case manager in such scenarios: connecting patient to resources, educating family, etc. But progress might be slow if, say, the patient cannot afford the recommended medication or can't attend therapy regularly due to transportation issues. Creative problem solving (finding low-cost options, telehealth sessions, involving social services) becomes part of treatment. Each challenge requires a tailored approach. Patience and persistence are key – helping the patient and sometimes other providers to stay the course. Celebrating small victories and reminding everyone involved that improvement is often nonlinear can maintain morale. Also, leveraging any improvement in the medical condition as evidence ("See, when your thyroid levels improved, your anxiety dropped 50% – this is working!") can motivate further adherence to the plan. Working on a *strong therapeutic alliance* is particularly crucial here, as the patient needs to trust that the clinician believes them about their physical symptoms and is using all tools to help. When that trust is present, patients are more willing to engage in psychological strategies and the combined treatment tends to succeed despite the challenges.

Prognosis with Treatment	**Prognosis is generally favorable** with proper treatment, because removing the cause often removes the symptoms. Specific prognostic points: **If the underlying medical condition can be cured or well-controlled, prognosis is excellent.** Many patients experience a near-total resolution of anxiety once the physiological trigger is addressed [39] . For example, after surgical removal of a pheochromocytoma, the panic attacks disappear. After successful treatment of hyperthyroidism, the person often returns to their baseline non-anxious state. They may not require long-term psychiatric medication once recovered (though sometimes a tapering period is wise). In such cases, therapy can often be brief, focusing on coping until cure and then relapse prevention. **If the medical condition is chronic but manageable, prognosis is good with ongoing management.** For instance, an asthmatic who experiences anxiety when breathing is compromised can learn to manage both, and as long as their asthma is managed with medication and they practice anxiety-reduction techniques, they can live with minimal interference. They might have occasional anxiety flares if asthma worsens, but overall function can be normal. They may need intermittent therapy tune-ups or medication adjustments, but not continuous intensive care. **If untreated or unrecognized, the anxiety tends to persist or worsen.** Patients who don't receive proper combined treatment often develop a chronic anxiety condition. They might start to develop additional complications like depression or heavy avoidance behavior that becomes disabling [40] . Moreover, an untreated medical cause could itself worsen (e.g., unchecked hyperthyroid can cause cardiac issues). Historically, once the cause is identified and treated, even longstanding anxiety can dramatically improve, so correct diagnosis is pivotal for prognosis. **Therapy outcomes:** Psychotherapy like CBT has demonstrated lasting effects – many patients maintain their gains after therapy ends [77] . If the cause is resolved, the recurrence is low. If the cause remains (chronic), then therapy equips them to handle ongoing challenges, and they usually have a much better quality of life and lower anxiety baseline than before treatment. Some might continue in maintenance therapy (maybe monthly sessions) just to reinforce skills in the face of a chronic illness. **Medication outcomes:** Typically, SSRIs and other meds effectively reduce symptoms by 50-75% in anxiety disorders. In secondary anxiety, if the physiologic trigger is still partly there, medications can control symptoms well enough that the patient feels significantly better. With good adherence, many remain symptom-controlled. If the medical illness is cured, psychiatric meds can often be tapered off after some time without relapse. If the patient needed benzos temporarily, they can usually be discontinued once stability is achieved. Long-term med needs depend on whether any residual or primary anxiety persists. **Overall functioning:** With successful treatment, patients often return to premorbid levels of functioning. E.g., someone who had to quit work due to uncontrolled anxiety attacks may resume work duties after treatment, or someone homebound can travel again. Prognosis in terms of disability is quite good if the cause is treatable; these are not typically lifelong psychiatric disabilities unless the medical condition is also lifelong and severe (even then, it can be managed). **Key prognostic indicators** include: how treatable the

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	medical condition is (e.g., an easy fix vs. a progressive illness), how quickly treatment is initiated (early intervention prevents secondary complications), and the patient's own resources (compliance, support system). When things align well – early diagnosis, strong patient engagement, effective medical therapy – patients often experience substantial relief within a few weeks to months. They may describe it as "I feel like myself again" once the medical condition is under control and the anxiety subsides. One caveat: if a patient had a latent predisposition to anxiety, the episode could potentially trigger a longer-term anxiety tendency even after cure (like kindling). But in practice, many will fully revert to baseline once the physiological stress is gone, especially if they learned coping skills for any residual stress. Thus, the *long-term prognosis is often very good, especially compared to primary anxiety disorders*, since removing the trigger can remove the disorder.

Sleep and Nutrition Considerations	**Sleep:** Adequate sleep is vital for these patients, as sleep deprivation can significantly worsen anxiety and even precipitate panic (by increasing sympathetic drive). Yet anxiety and some medical conditions often disrupt sleep. For example, hyperthyroidism can cause insomnia; asthma might wake a patient at night (nocturnal dyspnea) and cause panic; anxiety itself leads to racing thoughts that delay sleep onset. We counsel on good **sleep hygiene**: regular sleep schedule, avoiding screens before bed, keeping the bedroom cool and dark, etc. If needed, short-term sleep aids may be used – e.g., low-dose trazodone or melatonin or even a benzodiazepine for a limited time – to re-establish sleep. As anxiety improves, sleep usually follows suit. It's important to also manage any medical causes of sleep disruption (like giving asthma meds to prevent nighttime symptoms, treating pain, etc.). If the patient has nocturnal panic attacks, techniques like learning calming breathing and not avoiding sleep (because some become afraid to sleep) are addressed in therapy. Overall, improving sleep usually reduces daytime anxiety levels, creating a positive cycle. **Nutrition:** Diet can play a role in managing anxiety: - We strongly recommend **limiting caffeine and other stimulants** [57]. Caffeine (coffee, energy drinks, certain teas, chocolate) can provoke jitters, palpitations, and insomnia, mimicking or worsening anxiety. Many patients see improvement simply by cutting down or eliminating caffeine. Similarly, avoiding pseudoephedrine (decongestants) and other OTC stimulants is advised. **Regular meals and blood sugar stability:** For patients prone to hypoglycemia (e.g., diabetics on insulin, or reactive hypoglycemia), maintaining consistent nutrition is crucial. Skipping meals can lead to low blood sugar which triggers adrenaline release and anxiety. So we emphasize eating regular, balanced meals with adequate protein and complex carbs to avoid spikes and crashes. Some carry quick snacks in case they feel shaky. **Avoiding alcohol excess:** While some may attempt to self-medicate with alcohol, it can disturb sleep and cause rebound anxiety or interact with meds. We advise moderation – alcohol can worsen quality of sleep and cause dehydration and anxiety next day (“hangxiety”). If the patient drinks daily to calm nerves, we address that as both a nutritional and substance issue (perhaps substituting with non-alcoholic calming teas, etc.). **Hydration and electrolytes:** Dehydration can cause palpitations or lightheadedness, which might be misinterpreted as anxiety. Patients are encouraged to stay hydrated. Also, conditions like adrenal insufficiency or others require salt or electrolyte management – following those dietary recommendations will help prevent anxiety due to electrolyte imbalances. **Micronutrients:** In some cases, deficiencies can contribute to anxiety (like low B12 or magnesium). A healthy diet or supplements if needed (e.g., if malnourished or after gastric surgery, ensure B12 levels; if diuretic use, ensure not low on magnesium/potassium which can cause palpitations). While not for everyone, it’s something the medical team might manage. We caution against mega-dose supplements unless needed, but a general multivitamin is fine. **Comfort and digestion:** GI symptoms from anxiety can impact appetite. Encouraging small, frequent meals if they have nausea, or ginger tea for stomach calming can be practical advice. Conversely, some may stress-eat; if weight gain is an issue,

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	dietitian input might be needed so that they don't develop other health problems (like weight gain complicating diabetes or blood pressure). In therapy, sometimes patients track their sleep and diet along with anxiety to find patterns. Many notice improvement in anxiety when they cut caffeine or regularize eating. We provide education like "Nutrition for anxiety" handouts which mention things like avoiding excessive sugar (big sugar spikes and crashes can feel like anxiety swings). Also, we note to avoid any supplements that claim to cure anxiety without consulting doctor – some "natural" products (ma huang, high-dose thyroid supplements, etc.) can actually cause anxiety. **Summary:** Prioritizing good sleep (maybe even a short-term nightly routine with herbal tea, relaxation exercises) and a balanced diet without stimulants lays a strong foundation for recovery. Sleep and nutrition are sometimes neglected aspects, but addressing them can significantly reduce baseline physiological stress, making the other treatments more effective.

Exercise and Movement	**Exercise** has well-documented benefits for anxiety reduction, but it must be approached carefully here: **Benefits:** Regular exercise can help burn off excess adrenaline, reduce muscle tension, improve mood via endorphins, and regulate sleep – all of which reduce anxiety. It also increases cardiovascular fitness, which might raise the threshold for anxiety symptoms (e.g., a fit person might not get as fast heart rate spikes). For many, exercise is empowering – it restores a sense of control over one's body and can reduce health anxiety if done successfully ("my body can handle activity, I'm not as fragile as I feared"). **Challenges:** Initially, exercise can *mimic anxiety symptoms* (heart pounding, shortness of breath, sweating). This is often a trigger for panic, especially if the patient has been avoiding exertion. So, we don't just tell someone to start running 3 miles – we introduce movement gradually and often in a therapeutic context. Interoceptive exposure during therapy might involve light exercise to get them used to those sensations without fear. We often start with mild exercise (walking, gentle yoga) and then increase as tolerated. If a patient had a serious cardiac event, clearance from their cardiologist for exercise is mandatory and a tailored cardiac rehab program might be used. For others, a simple walking program might begin with 5-10 minutes daily and slowly increase. **Types of exercise:** For anxiety reduction, *aerobic exercise* (like brisk walking, jogging, swimming, cycling) is particularly helpful if tolerated, as it modulates the autonomic nervous system over time. **Yoga and tai chi** are also excellent because they combine movement with breathing and mindfulness – studies show they can decrease anxiety and are gentle on the body. **Strength training** can be included too; some prefer it. The key is the patient should enjoy it and not find it too aversive. If joint or other issues limit options, even chair exercises or physical therapy-guided routines can keep them moving. **Frequency:** A realistic goal might be moderate exercise ~3-5 times a week for 30 minutes (American Heart Association guidelines), but we often start much smaller as noted. The patient's medical status dictates some of this – e.g., in post-heart attack patients, often a monitored exercise program (cardiac rehab) is done initially. We encourage any safe increase in physical activity, even daily chores or gardening counts. **Monitoring during exercise:** For those with medical conditions, we might advise using tools: e.g., a heart rate monitor to ensure their pulse stays in a safe range if that's an issue, or a rescue inhaler handy for an asthmatic. Over time, as confidence builds, they often don't need these safety behaviors as much. But initially, it helps them feel secure enough to try. **Movement in daily life:** Beyond formal "exercise sessions," we encourage staying physically active in general. Avoid long sedentary periods which can worsen stiffness and anxiety feelings. Even simple actions like stretching, taking short walking breaks, or practicing breathing exercises with movement (like progressive muscle relaxation) can help break the cycle of bodily tension. We also counsel that exercise should be balanced with not pushing too far beyond what their condition allows. It's not "no pain no gain" in this context – it's about gentle, regular movement and gradually expanding capacity. Overexertion could backfire by causing injury or symptom flare (e.g., excessive exercise could provoke arrhythmia in a heart patient). So we often coordinate with physical therapists or medical advice on how to ramp up safely.

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	 Many patients, once they overcome the initial fear, find exercise to be one of the most empowering parts of recovery – e.g., someone might say, "I went for a hike and even though my heart pounded, I used my breathing techniques and it was fine, and I felt great after." Those experiences can really rebuild confidence in their body.

Mindfulness / Spiritual Practices	**Mindfulness and spiritual practices** can significantly aid in calming the mind and body: **Mindfulness Meditation:** Training patients in mindfulness – focusing on the present moment non-judgmentally – helps break the cycle of anxiety about symptoms. By learning to observe sensations (like a pounding heart) as transient events without immediately reacting with fear, patients gain control. Techniques include breath-focused meditation, body scan meditations, or mindful awareness exercises. Even a simple practice of 10 minutes of daily meditation can lower baseline anxiety. Many find that if done consistently, they respond less fearfully to the physical sensations because they've practiced just noticing and letting them pass. MBSR courses (8-week programs) have been specifically shown to reduce anxiety and stress in those with medical illnesses. **Breathing exercises:** Mindfulness often starts with breathing. Teaching **diaphragmatic breathing** or **4-7-8 breathing** helps activate the parasympathetic nervous system. It's both a mindfulness practice (because you focus attention on the breath) and a physiological calmer. Patients are instructed to use slow breathing when they feel anxiety building – e.g., inhale for 4 seconds, hold 7, exhale 8, which can reduce heart rate and dizziness. With practice, this becomes a go-to tool during prodromal anxiety sensations. It's portable and empowers them to regulate panic onset. **Yoga and Tai Chi:** These practices combine physical movement with mindful awareness and breathing, offering trifecta benefits (exercise, relaxation, mindfulness). Many patients find yoga classes or home practice helpful in reducing general anxiety and improving sleep. Gentle yoga in particular can be adapted for various physical abilities. Tai chi, with its slow deliberate movements and focus, has evidence for reducing stress in medical populations. They also have a spiritual dimension for some, which can enhance a sense of peace and acceptance of one's body. **Guided imagery and relaxation:** This can be considered a mindfulness-related practice – guiding patients to imagine a safe, serene scene (like a beach or forest) can shift focus away from symptoms and reduce anxiety. It's often used in hospital settings or before medical procedures to calm patients. Apps or audio recordings are available for home use. Over time, patients can learn to "go to their calm place" mentally when anxious, which can short-circuit panic. **Religious/Spiritual coping:** If the patient is religious, encouraging them to use their spiritual practices (prayer, reading scripture, attending services if able) can give comfort. Many draw strength and meaning through faith which mitigates anxiety (e.g., "placing trust in God's plan" can reduce fear of death or the unknown). However, ensure they also follow medical advice – prayer is wonderful but should complement, not replace, other treatments. Some may find practices like **mindful prayer** or repeating mantras (like the rosary or others) to be soothing and focus-providing. If their tradition includes **meditative prayer or chanting**, that can serve similar function to mindfulness meditation in reducing anxiety. **Biofeedback and meditation devices:** There are devices that provide feedback on heart rate variability or galvanic skin response to help patients learn to enter a relaxed, mindful state. These can gamify mindfulness (for example, a sensor shows a leaf floating when you're calm and sinking when you're tense, training you to calm it). Not necessary for all, but tech-savvy patients might benefit. We

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	typically introduce these gradually. For example, a therapist might start sessions with a brief mindfulness exercise to both teach the skill and get the patient in a calm state to proceed. Homework could include using a mindfulness app daily (like Headspace or Calm) for 10 minutes. Over time, patients often become quite fond of these practices as they notice the tranquility that comes with them. They are skills that last a lifetime and can be used even if the medical condition or other stresses return in the future. It's also worth noting that **mindfulness can help with pain** and other somatic symptoms that often accompany medical conditions, thus indirectly reducing anxiety by improving overall comfort. In summary, integrating mindfulness or spiritual practices taps into the patient's internal resources for peace. It shifts them from the fight-or-flight state to a rest-and-digest state more often, counterbalancing the physiological stress. Because these practices are generally safe and free (aside from maybe yoga class fees), we strongly encourage them as part of a holistic treatment plan.

Community or Social Support Needs	**Social support is a protective factor** in virtually all mental health conditions, including this one. We encourage patients to make use of and enhance their support systems: **Family and friends:** Educating close family about the disorder allows them to be more supportive and less frustrated. Family can help in concrete ways: accompanying patient to doctor visits if the patient is anxious, helping monitor medication schedules, providing reassurance appropriately ("Remember, the doctor said it's just your thyroid acting up, let's do your breathing exercise together"). We advise families to be patient and not dismissive. Sometimes family therapy or a brief family meeting is held to align everyone on how to handle episodes (for instance, teaching a spouse not to panic when the patient panics, but instead to remain calm and coach breathing, etc.). A supportive friend who can be called during high anxiety for a calming chat is a great asset – the patient might set up a "buddy system" for tough moments. **Support groups:** Being in touch with others who have similar issues can be immensely validating. There are **support groups for anxiety** (e.g., through Anxiety and Depression Association) where patients share coping strategies. There are also illness-specific support groups (for cancer, cardiac rehab, etc.) where patients often discuss emotional aspects. If available, a group for "health anxiety" or "anxiety in medical illness" could normalize their feelings. Nowadays, there are also online forums and communities – though we caution to use reputable ones (some forums might inadvertently increase anxiety with horror stories). But connecting even online with peers ("I also had an adrenal tumor and these panic attacks – here's how I coped…") can reduce isolation. **Community resources:** Encourage use of community programs like **exercise classes** tailored to health conditions (e.g., YMCA classes for cardiac rehab or gentle yoga at community centers), which serve double-duty as social outings. Volunteering or attending faith-based group activities (if health allows) can also rebuild social engagement and distract from anxiety. The goal is to prevent social withdrawal which can otherwise occur. **Professional support:** Sometimes the patient might benefit from **case management or peer support specialists** (people who have lived experience of mental health issues). Also, if needed, social workers can assist with resources – for example, linking to transportation services if anxiety prevents driving, or home health if anxiety plus illness limit them from going out. In complex cases, having a **care coordinator** to tie together the care team (especially if multiple specialists are involved) can reduce the patient's stress of managing appointments and information. **Communication plans:** We might set up a plan for how the patient can reach support in crisis. For example, having a close friend or family member on-call if they feel overwhelmed, or knowing which crisis line to call. Even if rarely used, knowing support is available can be anxiety-relieving. Some patients wear a medical alert necklace or have an emergency plan (like if they truly have a risk condition, they might have a way to call ambulance quickly). Once those contingencies are in place, paradoxically they often feel safer and need them less. Overall, we aim to **foster a network** around the patient so they don't feel alone in dealing with this. Social support not only provides practical help, but also emotional reassurance that others care and that their experiences are understood. We do counsel patients to communicate

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	with loved ones about what helps vs. doesn't (e.g., "When I'm anxious, I just need you to sit with me quietly, not tell me to calm down"). This helps avoid well-meaning but unhelpful responses. For patients with limited support, therapy might focus on building some (maybe joining a group, or even adopting a pet for companionship which can have calming effects). **Community-based programs** like NAMI (National Alliance on Mental Illness) family education classes can teach families how to support someone with an anxiety condition. If stigma in the community is an issue, part of our work might be advocacy or connecting the patient with less stigmatizing sources of support (like maybe they trust their pastor, so involving that person with education if appropriate). In summary, a well-supported patient tends to have a smoother journey. Social connections can buffer stress, provide encouragement in doing exposure exercises ("I'll walk with you each morning"), and ensure the patient has help if symptoms spike. As clinicians, facilitating these support structures (via education, referrals, encouragement) is an important part of the treatment plan.

Routine and Structure Guidance	**Establishing a daily routine** can provide stability that counteracts anxiety. When patients are dealing with unpredictable symptoms, creating some predictability in other areas of life restores a sense of control. Key points we often guide: **Consistent daily schedule:** Encourage waking up and going to bed at regular times (ties into sleep hygiene). Regular meal times as well, to avoid physical stress of hunger or low blood sugar. Having a general plan for the day – even if small tasks – can reduce idle time that might otherwise be filled with worry. For example, 7am wake, morning walk at 8am, breakfast 9am, etc. We might help the patient craft a realistic schedule given their energy levels and commitments. If they're not working due to illness, structure becomes even more important to prevent excessive rumination time. **Balanced activity and rest:** A good routine alternates activity with relaxation. We advise scheduling *some* productive or enjoyable activity each day (could be as simple as watering plants or reading for 30 minutes) as well as time for relaxation exercises or leisure. Too much downtime can allow anxious thoughts to take over, but too much activity can overwhelm – so balance is key. A routine might include a mid-day relaxation break (listen to calming music or do a meditation at 1pm, for instance). **Gradual re-engagement:** If the patient has been avoiding certain tasks (like driving or going to grocery store due to panic), we help incorporate *graded exposure* into their routine. For example: Monday – sit in car for 10 minutes practicing breathing (engine off); Wednesday – drive around block with spouse; Friday – drive 10 minutes alone. This scheduled practice ensures systematic progress. Over a few weeks, these become routine activities no longer provoking anxiety. **Cue-triggered coping routines:** We might add structure specifically around triggers. Example: every time before checking blood pressure (if that's anxiety-provoking), the patient does a 2-minute breathing exercise. Or every evening, they write down any health worries in a journal and "close" it, then do something relaxing – creating a routine of containing worry to a certain time ("worry time") so it doesn't pervade the whole day. **Maintaining routine during medical ups/downs:** We counsel that even if a medical symptom flare happens, trying to keep some routine (even if adjusted) helps mental well-being. For instance, if they normally walk 30 min but today their arthritis is painful, do a shorter gentle stretch routine instead of just scrapping everything. The continuity prevents feelings of chaos. Similarly, continuing to take care of personal hygiene and household tasks to the extent possible – these structured daily activities can impart a sense of normalcy and accomplishment, which fights feelings of helplessness. Patients sometimes resist structure if depression or lack of motivation is present, so we may start small ("let's at least set a consistent wake time this week"). Sometimes anxiety itself leads to over-structuring (some become rigid to cope). In those cases, if a patient's routine is too inflexible and any change triggers anxiety, therapy will work on introducing flexibility gradually – because life won't always fit a strict schedule. So the goal is a **flexible but stable routine**. We often provide templates or ask patients to fill out an activity schedule for the week as homework, then review and refine it. This helps them be intentional about their time rather than letting anxiety dictate it. A predictable routine can also reassure the body's clock – for

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	instance, regular exercise and meal times regulate circadian rhythms, which in turn improve sleep and mood. **In sum:** Structure instills a sense of order and predictability, reducing the "unknowns" that fuel anxiety. It also helps ensure the patient allocates time to the various components of treatment (meditation, exercise, etc.) rather than just intending to but forgetting. Over time, these structured practices become habits, and the patient often reports feeling more grounded. Routine acts like a scaffold supporting them as they recover and eventually they may not need such deliberate structuring, but it's a useful tool especially early on.

Children & Adolescents	In younger populations, this disorder is comparatively rare, but it does occur and has special considerations: **Prevalence and causes in youth:** Children generally have fewer chronic medical conditions that provoke anxiety, but there are exceptions. Conditions like **asthma** are common in kids and can cause panic-like episodes when the child can't breathe. **Seizure disorders** or **migraines** might also cause anxiety symptoms (some kids become very anxious before or after a seizure due to neurochemical changes). **Thyroid disorders** can occur even in adolescence, though less frequently than in adults. Another scenario is **PANS/PANDAS** (pediatric autoimmune neuropsychiatric syndrome) where a strep infection triggers sudden OCD/anxiety in a child – that's an example of anxiety due to a medical/autoimmune process. Also, children on **steroid medications** (e.g., for autoimmune disease) can exhibit anxiety and mood changes as a side effect. **Presentation differences:** Young children might not have the insight or vocabulary to say "I'm anxious." Instead, they show it through **behavior**: irritability, clinginess, crying, tantrums, trouble at school, or somatic complaints like stomachaches and headaches. A child with undiagnosed hyperthyroidism might just seem fidgety, moody, and have trouble concentrating. Adolescents might articulate anxiety more like adults, but sometimes it comes out as **avoidance of school or activities** or acting out. It's important to differentiate normal developmental fears from this disorder – e.g., a teen with Type 1 diabetes might reasonably worry about managing blood sugar (normal adjustment), versus excessive panic attacks whenever sugar drops (could be this disorder). **Assessment:** Pediatricians will often pick up on physical causes (they usually screen thyroid, etc., if a child presents with new anxiety and weight loss or tachycardia). A **comprehensive workup** is similarly needed in kids when anxiety symptoms are atypical or have physical signs. Also, input from parents and teachers is crucial to see how the child is functioning across settings. Sometimes what looks like "ADHD" (restlessness, inattention) could be anxiety due to something like pheochromocytoma – extremely rare in kids, but underscores why a medical evaluation is key. Childhood anxiety disorders are more often primary (like separation anxiety, social anxiety), but we keep an eye out for medical contributions (e.g., frequent caffeine from soda can even trigger anxiety symptoms in kids!). **Treatment modifications:** Therapy such as **CBT** is effective for children and teens, but it must be made age-appropriate. For younger kids, techniques might involve more play therapy elements or use of pictures/characters to externalize anxiety ("the worry monster"). Family involvement is crucial – parents often need to be trained in how to respond supportively and not inadvertently reinforce anxiety by over-accommodating or by dismissing the child's fears. For example, if a child has panic due to asthma, the parent should learn to calmly administer the inhaler and coach the child's breathing, rather than panic themselves or keep the child out of all sports (which could reinforce avoidance). **Medications:** If needed, SSRIs like **fluoxetine or sertraline** are commonly used for anxiety in youth, at lower starting doses. There is good evidence for SSRIs in pediatric anxiety. Benzodiazepines are used much more cautiously (concern for learning/memory effects in developing brains, and risk of dependency especially in teens). In acute hospital settings, a short-acting

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	benzo might be used if a teenager is having an uncontrollable panic attack, but generally therapy and SSRIs are preferred. Any underlying condition, e.g., adjusting insulin regimen in a diabetic teen to prevent hypoglycemia, is primary. *Beta-blockers* can be used in older adolescents (say, a 17-year-old with hyperthyroid tremors) but in younger kids it's less common unless cardiologist approves. **Prognosis in youth:** If properly treated, kids usually bounce back well – their brains are plastic and they often don't have long-standing avoidance habits yet. They might need some catch-up if anxiety kept them out of school or activities, but with support they reintegrate. Ensuring they don't fall behind academically or socially during the treatment phase is important (e.g., maybe a partial school day or home tutoring if needed, gradually back to full school as anxiety allows). Early intervention is key to avoid the child developing a lifelong anxiety pattern. Also, treating any co-parental anxiety (often anxious kids have anxious parents) can help the child's outcome. **Special pediatric note:** Sometimes kids with serious medical conditions (like childhood cancer survivors) develop anxiety not from a direct physiological cause but from the trauma of procedures – that's more PTSD or adjustment, not this disorder. But occasionally, treatments (like chemotherapy, steroids) can directly induce anxiety symptoms physiologically. In those cases, it overlaps with this category. For example, if high-dose steroids make a child wildly anxious, one might use the "due to another medical condition" label temporarily. The treatment would then involve possibly adjusting the steroid dose/timing, and lots of reassurance and comfort measures. In sum, while uncommon, secondary anxiety syndromes in children do happen. The approach is similar – treat the cause (e.g., control asthma better) and support the child with therapy – but always involving family and considering developmental context. The good news is kids generally have excellent resilience and can recover fully, continuing along their developmental path once the internal trigger is resolved and they've learned a few coping skills.

Older Adults	In older adults, this diagnosis is particularly pertinent because late-onset anxiety is often medically based. Considerations include: **Higher index of suspicion:** Clinicians maintain a high suspicion of medical causes for new anxiety in an elder. As noted, if a 70-year-old with no psych history suddenly develops anxiety symptoms, one immediately screens for things like hyperthyroidism (which could be apathetic hyperthyroid in elderly), occult cardiac ischemia (presenting as anxiety, sometimes called "angor animi"), vitamin B12 deficiency, etc. Also, **medication side effects** are a big one – older adults may be on multiple meds, and some (like bronchodilators, corticosteroids, antidepressants, stimulants for appetite, etc.) can cause anxiety symptoms. So part of evaluation is reviewing the med list for culprits (e.g., too high a dose of thyroid replacement causing anxiety, or albuterol overuse). **Presentation:** Older adults might present anxiety differently – often more somatic complaints (dizziness, shortness of breath) and less of the "I feel worried" verbalization. They might attribute feelings to physical problems entirely ("I have palpitations and can't breathe" without labeling it as anxiety). Some may minimize psychological aspects due to generational stigma. On the other hand, some older patients might present with **agitation, irritability, or confusion** when anxious, leading providers to consider delirium or dementia first. It can be tricky to disentangle, especially if mild cognitive impairment is present. Observing whether anxiety symptoms occur in clear consciousness (pointing to anxiety) versus with disorientation (pointing to delirium) is important [20] . **Comorbid cognitive decline:** Many older patients have some cognitive impairment. Anxiety can worsen cognition (an attentive older person might look mildly confused if very anxious), and conversely, cognitive impairment can make the patient more prone to anxiety (because they can't remember if they took meds, etc., they become anxious). In cases of coexisting mild dementia, we often treat the anxiety to improve comfort, but we might not label it "due to another medical condition" if it's more a psychological reaction to memory loss – unless the dementia's pathology itself is causing the anxiety (some dementias like Lewy body can cause marked anxiety as a direct effect). ICD-11 even suggests using an "anxiety in dementia" specifier instead of separate diagnosis if anxiety occurs solely in the context of dementia [78] . For practical purposes, if an older patient with dementia has significant anxiety, we treat it similarly, but prognosis might depend on dementia progression. **Medication in elderly:** We are cautious: SSRIs are generally safe but older adults may be more sensitive to side effects like hyponatremia or GI upset. Start low, go slow. Benzos are usually avoided or used very sparingly short-term, because they contribute to falls, cognitive impairment, and can paradoxically cause agitation in some elders. Buspirone is a great option in elderly as it's well-tolerated and non-sedating. Beta-blockers need watching for orthostatic hypotension in older patients. We also must consider polypharmacy – coordinating with their PCP to simplify regimens if possible. Non-pharmacological approaches (therapy, relaxation) are extremely important since they avoid adding burden to a possibly long medication list. **Therapy approach:** CBT can be effective for older adults, though it may be adjusted for sensory or cognitive limitations. For instance, written materials in large print,

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	repetition of concepts, including a family caregiver in sessions to help practice skills, etc. Older adults might also benefit from **reminiscence therapy or narrative therapy** – leveraging their life experience of overcoming challenges to apply to the current anxiety. Many elders have coped with adversity; reminding them of those strengths ("you got through wartime or raising 5 kids – you have resilience to get through this health scare too") can instill confidence. Also, addressing existential anxieties (fear of mortality often underlies health anxiety in elders) might be needed – sometimes meaning-focused therapy or involving chaplaincy can help with the deeper fears of death or disability that fuel anxiety. **Social factors:** Many older adults live alone, which can heighten anxiety ("what if something happens and nobody's here?"). Part of management may be ensuring they have emergency response systems (like LifeAlert) – ironically, having that button can reduce anxiety. Also connecting them with community (senior centers, etc.) so they are not socially isolated. If the anxiety is severe, short-term home health aide or family staying over might be needed until it's controlled, to provide reassurance and safety. **Prognosis:** If the cause is treatable (e.g., fixing a metabolic issue), older adults can certainly improve, though perhaps slower due to frailty or co-morbid conditions. If anxiety has led to physical deconditioning or loss of independence, rehab might be needed to regain functionality. Ensuring they adhere to treatments can be a challenge if memory is an issue – simplifying regimen or having a nurse help might be needed. With comprehensive care, many older patients do get much better (e.g., an 80-year-old with undiagnosed hyperthyroid and anxiety becomes relaxed and stable once treated). However, if underlying causes are things like neurodegenerative diseases, then anxiety might wax and wane with disease progression and need ongoing management. Even so, improving comfort and reducing distress is a realistic goal and often achievable with the right interventions. In summary, older adults require a **geriatric-sensitive approach**: thorough medical workup, careful med choices, integration of therapy with their life experience, and additional supports to account for any sensory/cognitive limitations. The disorder is often *curable* if cause is found (giving very good prognosis) – and if not curable, at least *manageable*.

Pregnancy & Postpartum	During pregnancy and postpartum, physiological changes can provoke anxiety, and special care is required due to concerns for the baby: **Medical triggers in pregnancy:** Pregnancy involves endocrine flux (dramatic changes in hormones like estrogen, progesterone, cortisol) which can affect neurotransmitters and emotional regulation. Many pregnant individuals report heightened anxiety or new onset panic. Some medical conditions specifically associated: **Thyroid dysfunction** is not uncommon in pregnancy/postpartum – e.g., some women develop *postpartum thyroiditis* which can cause transient hyperthyroidism (thus anxiety, palpitations) followed by hypothyroid phase. **Preeclampsia** (high blood pressure in pregnancy) can cause symptoms like headaches, shortness of breath, and the situation itself is anxiety-provoking – sometimes it's tricky to tease anxiety vs symptoms of high BP. Also, **anemia** in pregnancy might cause palpitations and breathlessness that feel like anxiety. **Postpartum**, huge hormonal withdrawal (drop in estrogen/progesterone after delivery) and sleep deprivation can set the stage for anxiety. Some women develop *postpartum anxiety* or exacerbation of OCD symptoms (possibly hormonally influenced). So it's not rare to see "anxiety disorder due to another medical condition" in the postpartum period, like anxiety due to thyroiditis or due to an infection or other complication. **Medication considerations:** During pregnancy, we try to minimize medications if possible, especially in the first trimester. **SSRIs** are relatively safe (e.g., sertraline is often the go-to if needed, as it's well-studied in pregnancy with low risk). Benzodiazepines in first trimester carry a slight risk of cleft palate and later can cause floppy infant syndrome if used near delivery; they are not first-line, but a short-acting benzo could be used sparingly for severe panic if the mother's health is at risk (risk/benefit weighed). **Buspirone** is Category B (considered fairly safe in pregnancy, though data is limited) – it's a decent option for chronic anxiety as an alternative to benzos. Beta-blockers like propranolol are sometimes used for performance anxiety in pregnancy (they can cause fetal bradycardia or growth restriction in high doses, but occasional use is generally okay). We coordinate closely with OB on any med decisions. Postpartum, if breastfeeding, similar caution – most SSRIs (sertraline, paroxetine) appear in low levels in breast milk and are considered compatible with breastfeeding by most experts [71] . The key is involving pediatricians too, to monitor the baby if needed (for example, an infant might be watched for sedation if mom is on clonazepam while nursing). **Therapy focus:** Non-pharmacological strategies are primary in pregnancy. We use a lot of **CBT, relaxation, and mindfulness** to manage anxiety so that medication can be minimized. For example, a pregnant woman with panic attacks might undergo CBT with interoceptive exposure (like gently raising heart rate through step exercises) to learn not to fear those sensations, rather than immediately resorting to a benzo. Many find prenatal yoga or meditation classes helpful (commonly offered, and double as social support). Also, **childbirth education classes** can reduce anxiety by increasing knowledge – fear of the unknown or of labor can cause great anxiety, and education addresses that. **Postpartum support:** The postpartum period is high risk for mood/anxiety disorders (hormone changes, immense life adjustment, sleep loss). A new mother might present with intense anxiety about the baby's

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health or her own – sometimes related to medical events like a difficult labor (trauma) or due to thyroid changes as mentioned. We ensure that postpartum patients get plenty of support: involvement of spouse/partner or family to give breaks (sleep, self-care), possibly a referral to a **postpartum support group** or home visits by a nurse if available. If anxiety is severe (like postpartum panic or OCD with intrusive thoughts of harm), we move quickly to treat because it can impair mother-infant bonding or the mother's ability to care for the baby. Therapy (CBT, possibly medication if needed) is initiated. Fortunately, postpartum thyroiditis if present often resolves on its own, but while hyperthyroid phase is on, a beta-blocker may be given to control symptoms, and that in turn eases anxiety. If an underlying cause like infection (e.g., postpartum infection causing delirium and anxiety) is treated, anxiety resolves.
Breastfeeding considerations: For mothers who need medication, we choose those with the best safety profile in lactation (sertraline is often first-line SSRI since infant exposure via milk is minimal). We also monitor infants for any sedation or poor feeding if mom is on psych meds, though adverse effects are rare at typical doses. Some mothers feel anxiety about taking meds while breastfeeding (fear of harming baby) – we provide thorough risk/benefit counseling. Untreated severe anxiety in mom can also affect baby (for instance, if mom is too anxious to sleep or eat, that's not good for baby either). So we frame it as treating mom to better care for baby. If a particular med is risky, we explore alternatives (e.g., maybe avoid clonazepam and instead do hydroxyzine or therapy for sleep).
Long-term outlook: Many postpartum anxiety conditions are time-limited – as hormones settle and life routine is established, the anxiety often improves within months, especially with treatment. We keep watch, though, because some women who experience postpartum anxiety or depression may be at risk for recurrences with future pregnancies or even later in life (there's some evidence postpartum issues predict sensitivity to hormonal changes like perimenopause mood changes). So it's important to plan for any future pregnancies (maybe prophylactic treatment or extra monitoring). Also, ensuring that the anxiety resolves is key for the well-being of both mother and child – unresolved postpartum anxiety could progress to chronic anxiety or contribute to postpartum depression. Usually with comprehensive care (OB + mental health), prognosis is good – mothers recover and bond well with their babies, and any short-term therapies (meds or counseling) can often be tapered after a period of stability.
Case example: A woman develops intense anxiety and palpitations 1 month postpartum. Workup shows her thyroid is in a transient hyperthyroid phase of postpartum thyroiditis. She is treated with a beta-blocker to slow heart rate and gets CBT for anxiety management. Her thyroid function normalizes over a few months, and by 6 months postpartum, her anxiety is gone and she's medication-free, enjoying motherhood. This is a typical scenario illustrating how pinpointing the cause and supporting the patient leads to full recovery.

LGBTQIA+ Considerations	There are no unique physiological triggers of anxiety specific to LGBTQIA+ individuals, but this population may face distinct issues that intersect with this diagnosis: **Hormone therapy in transgender individuals:** Trans men (FTM) on high-dose testosterone or trans women (MTF) on estrogen might experience mood and anxiety changes during dose adjustments. For example, high testosterone could potentially increase irritability or anxious energy in some, or fluctuating estrogen levels might cause emotional variability. If a trans person on hormone therapy experiences new anxiety, one consideration is whether the hormone dose is optimal or causing side effects. However, many handle hormones well; anxiety could also be from underlying medical issues unrelated to being trans. If anxiety is hormonally influenced, adjusting the dose or adding symptomatic treatment can help. E.g., some trans men report increased anxiety on testosterone that is managed by dividing doses or using anxiolytics short-term. **Minority stress:** LGBTQIA+ individuals often face chronic stress from discrimination or lack of support, which can heighten baseline anxiety. This isn't "due to another medical condition," but it can exacerbate any anxiety that does occur. If an LGBTQ+ patient has an illness that causes anxiety (say, hyperthyroid), the overall anxiety might be worse because they also carry minority stress. Or they may have had negative healthcare experiences that make medical settings anxiety-provoking (which can complicate treatment of their condition). Therapists should be aware of and validate these stressors and incorporate minority stress coping strategies. For example, connecting them to LGBTQ+ community support can reduce overall stress and improve coping with their health issues. **HIV and other health issues:** Gay, bisexual, and trans individuals have higher prevalence of certain medical conditions (e.g., HIV). HIV infection itself, if advanced or if CNS-involved, can cause anxiety (direct neurochemical impacts) – that would be anxiety due to a medical condition (HIV). Additionally, some HIV medications or other treatments (like interferon for hepatitis) can induce anxiety. So, when working with LGBTQ+ patients, it's important to consider conditions more prevalent in that group as potential causes. For instance, if an HIV-positive patient on antiretrovirals complains of anxiety, we'd review their regimen for drugs like efavirenz which is known to cause anxiety/insomnia. **Substance use:** Some LGBTQIA+ communities have higher rates of substance use (possibly as coping with stigma). Substances like stimulants (e.g., methamphetamine) cause anxiety – but that's substance-induced anxiety, not due to medical condition. However, long-term substances can lead to medical complications (like stimulant-related cardiomyopathy or hyperthyroidism or hepatic issues) which in turn cause anxiety physiologically. So thorough history is needed. The presence of substance use might cloud diagnosis initially. It's crucial to separate what is due to substance vs due to a physical illness. An accepting, nonjudgmental approach encourages honesty about substance use in this population who may fear stigma. **Access to care:** LGBTQIA+ individuals sometimes avoid medical care due to fear of discrimination. This can mean a medical condition goes undiagnosed longer, and the person might seek help for "anxiety" in mental health when actually it's a physical issue. Providers should be conscious of creating a welcoming environment (using correct

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	pronouns, etc.) so the patient shares all relevant info. For example, a trans man might not volunteer that he's post-hysterectomy and on hormones, unless asked in a respectful way – missing that would skip checking how testosterone might be affecting him. Building trust is key to doing a full medical evaluation. Therapy with LGBTQIA+ patients might also touch on how anxiety symptoms interact with identity and social context. For instance, hypervigilance (a trauma-related anxiety) could be due to a history of bullying for being gay – not "due to another medical condition," but it can coexist. Separating that out is important: we can treat the physiological anxiety and also possibly recommend trauma-informed therapy for the minority stress, if relevant. In summary, while LGBTQIA+ status doesn't biologically predispose someone to this disorder, their broader experiences can influence manifestation and management. Being culturally competent and attentive ensures proper diagnosis (not attributing everything to "anxiety from being LGBTQ" nor ignoring genuine distress from discrimination). The actual treatment of the medically-caused anxiety remains the same (fix the cause, use therapy/meds), but it should be done in an affirming manner, and additional support for identity-related issues should be provided or referred.

Substance Use Complications	**Substance use can complicate both diagnosis and treatment** of anxiety due to medical conditions: **Substance-induced anxiety vs. medical anxiety:** It's crucial to differentiate whether anxiety is coming from a medical condition or from substance use (or withdrawal). Many substances cause anxiety symptoms: stimulants (amphetamines, cocaine) can directly trigger panic; even heavy caffeine use can induce anxiety. Alcohol or benzodiazepine withdrawal is notorious for causing severe anxiety and autonomic arousal (sweating, tremor, etc.). Patients might have both – e.g., a heavy drinker who develops cardiomyopathy (medical condition) which then causes anxiety arrhythmias, *and* experiences anxiety during alcohol withdrawal bouts. In such cases, both "Alcohol Withdrawal Anxiety" and "Anxiety due to cardiomyopathy" could co-occur [24] . Clinicians should do a careful history and possibly toxicology tests to identify substances. As a rule, acute substance causes are addressed first (detox, etc.), and then remaining anxiety is re-evaluated. **Dual diagnosis approach:** If a patient has a substance use disorder along with anxiety due to a health condition, integrated treatment is needed. For example, someone using methamphetamine might develop weight loss and hyperthyroidism (medical cause) and also direct stimulant-induced anxiety – you must treat the hyperthyroid *and* get them off meth. That often means involving addiction specialists or support groups (NA/AA), possibly medication-assisted treatments (if opioid or alcohol issues). Without addressing the substance use, the anxiety will likely persist or recur. Also, continuing substances can sabotage medical recovery (e.g., cocaine could trigger cardiac issues making anxiety episodes continue). So a goal is complete cessation of illicit or non-prescribed substances. **Medication interactions & misuse:** Many anti-anxiety meds are controlled substances (benzos) or have abuse potential. If a patient has a history of substance misuse, prescribing benzodiazepines is fraught – they might overuse them or combine with other substances (dangerous). Alternatives like hydroxyzine, gabapentin (careful, gabapentin has some abuse potential but lower), or buspirone are preferred in such patients. SSRIs are fine (no abuse potential). If a benzodiazepine is absolutely needed short-term (say the patient is in severe adrenal tumor panic awaiting surgery and has a history of alcohol abuse), it should be in a controlled setting or with limited dispense and supervision by a trusted family member. We also avoid prescribing other potentially abusable meds like stimulants or certain sedatives unless clearly indicated. The presence of substances also means therapy might need a relapse prevention component. For instance, if they self-medicated anxiety with alcohol, therapy addresses developing healthier coping and maybe using non-addictive meds so they aren't tempted to drink for relief. **Substance-caused medical issues:** Some medical conditions causing anxiety are in fact due to long-term substance use. Example: alcohol abuse can lead to cardiomyopathy or gastritis, which cause palpitations or discomfort fueling anxiety. Stimulant abuse can cause weight loss and hyperthyroid-like state or even stroke. So part of treating the "anxiety due to medical condition" in these cases is treating the underlying substance-caused medical condition (which includes quitting the substance). If the damage is reversible (like quitting cocaine resolves palpitations), prognosis is good. If damage is permanent (like emphysema from

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	smoking causing constant shortness of breath and anxiety), then one manages the chronic condition and anxiety as best as possible, and absolutely enforce abstinence from further harmful substances (like no more smoking). **Relapse risk:** Anxiety can be a trigger for substance relapse – e.g., a patient in recovery from alcohol might start drinking again when anxiety from their illness spikes. Thus, part of treating the anxiety is preventive for relapse. We talk with patients about high-risk moments and encourage them to use the taught coping skills or non-addictive meds in those moments instead of turning to substances. Engaging them in addiction counseling or groups simultaneously provides an outlet to discuss these challenges. Also, ensuring any chronic pain (common in those with certain illnesses) is managed so they don't self-medicate with illicit substances is important (this may involve non-narcotic pain management or careful monitored use if needed). In sum, substance use adds layers to both cause and effect. The management principle is to **treat both** the substance issue and the anxiety/medical issue, ideally in a coordinated way (integrated dual diagnosis treatment). If one is left unaddressed, the other likely won't fully resolve. For instance, you can treat hyperthyroidism perfectly, but if the person keeps doing cocaine, they'll still be anxious; or you can get them off cocaine, but if you ignore a coexisting hyperthyroid, they'll still have panic from that. Both need care. Patients often require encouragement that life without substances will ultimately greatly help their anxiety – initially they may not believe it if they've been using to cope. With supportive therapy, many do achieve sobriety, and then we see a significant drop in baseline anxiety and more clear sailing in treating the remaining physiological anxiety. **Clinical pearl:** Always screen for substances in any new anxiety case – it's common and treatable. And consider that sometimes what looks like a pure substance issue might have started because of an unrecognized medical anxiety (someone might start abusing Xanax because of untreated pheochromocytoma panic episodes). Only by treating the cause can you break that cycle.

Suicidality / Risk Management	**Severe anxiety can lead to suicidal ideation**, though typically anxiety disorders have lower suicide rates than mood disorders. However, risk is not negligible, especially if the anxiety is chronic and accompanied by hopelessness or depression. Key points: **Assessment:** We always assess suicidality in anxious patients, particularly if they express statements like "I can't live like this" or show signs of despair. The patient might not be depressed in the classic sense, but constant, unremitting panic or terror can make someone feel life is not worth living. For example, someone with an adrenal tumor causing frequent panic attacks might become exhausted and feel hopeless about ever finding relief – those feelings can spark suicidal thoughts. Also, if the underlying illness is serious (like advanced cancer causing anxiety, though that might be adjustment disorder territory), suicidal ideation might arise from that context as well. Regularly asking in a gentle way ("Sometimes people with intense anxiety or health struggles have thoughts of not wanting to live; have you had any thoughts like that?") can open the door to a truthful answer [74]. We don't assume an anxious patient isn't suicidal just because they're anxious – we check. **Contributing factors:** Co-occurrence of depression significantly increases suicide risk. If an anxiety patient starts saying they feel hopeless, losing interest, can't sleep at all, etc., we might actually be seeing a developing depressive episode due to the stress of their condition. Substance use (particularly alcohol) can also lower inhibitions and increase risk of impulsive suicide attempt during an anxiety or panic attack ("I just wanted the fear to stop, so I took a bunch of pills" – this scenario is possible). Some medications, ironically, can transiently worsen mood (like beta-blockers occasionally cause depression, or steroids used for medical conditions can cause mood swings) – these might also influence suicidality indirectly. **Risk management strategies:** If a patient endorses suicidal ideation, we evaluate the nature (fleeting thoughts vs a plan/intent). If there's any indication of plan/intent or they feel on the edge, we may need emergent interventions: possibly hospitalization (especially if delirium or severe medical issues are also present), or at least creating a safety plan. Safety planning includes identifying warning signs, coping skills (e.g., use the plan – "if panic gets unbearable, do X, call person Y, or go to ER"), and removing means (e.g., if they have access to firearms or large quantities of lethal meds, ensuring those are secured). We also involve family if possible for monitoring. For instance, an older adult with severe anxiety might stay with family temporarily rather than alone if we worry about their safety. **Treat the anxiety to reduce risk:** Usually, as we aggressively treat the anxiety and its cause, suicidal ideation that was driven by desperation tends to recede. Sometimes a short-term benzodiazepine is justified for a patient in extreme distress with suicidal ideation simply to reduce that acute anguish and risk while other treatments take effect (with careful monitoring). Also, if depression is present, starting an antidepressant and/or therapy to target that is important. It's known that when anxiety coexists with depression, suicide risk is higher than either alone, so both need addressing. **Follow-up:** We tighten follow-up frequency if suicidality was a concern. Maybe phone calls between sessions, or involving a psychiatrist if only in therapy, etc. If any attempt occurred or serious ideation, we might involve crisis

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	services or partial hospitalization programs to stabilize them until outpatient treatment is sufficient. Family can help by keeping an eye on them, making sure they take meds properly, and being present during high anxiety periods. With the patient's consent, we might educate family on signs to watch and steps to take (like if patient says concerning phrases, family will call provider or take them to ER). In a scenario like this disorder, once the medical cause is properly treated, it's rare for suicidality to persist because the precipitating extreme anxiety usually abates. However, one must be vigilant for any residual depression or PTSD from the ordeal. For example, someone who endured months of undiagnosed severe anxiety may have lingering trauma from that experience ("I thought I was dying every day"). That psychological aftermath might require therapy (like trauma-focused therapy) to fully resolve, otherwise it could manifest as continued depression or intrusive memories which could still keep suicide risk slightly elevated. So comprehensive follow-up care is important even after physical cure. In conclusion, while not the top disorder associated with suicide, **the risk is real when anxiety is intense and unrelenting**. Proper screening and swift interventions (both psychosocial and medical) are needed to ensure safety. Our aim is to give hope – by explaining that effective treatments are available and many patients get dramatically better, we often can instill hope which itself diminishes suicidal thoughts that stem from hopelessness. And indeed, as treatment works, patients almost always report those earlier suicidal thoughts dissipating.

Early Warning Signs of Relapse

After successful treatment, knowing what signs herald a possible return of anxiety is crucial for preventing full relapse: **Physical signs re-emerging:** Because this disorder is tied to a medical condition, often the earliest warning is if the medical condition is returning or flaring. For example, if a patient cured of hyperthyroidism starts noticing **physical symptoms** like heart palpitations, heat intolerance, or tremors again, that might predict both the return of hyperthyroid and consequently the anxiety. So any recurrence of the underlying illness's signs is a red flag – patients are instructed to report such signs promptly to their physician (e.g., "If your thyroid nodules enlarge or you feel those same bodily symptoms, come in for labs immediately"). Similarly, someone with panic due to arrhythmia might be taught to monitor their pulse and note if irregularities creep back.
Subtle anxiety symptoms: Patients often have a sense for their personal early symptoms. It could be **trouble sleeping or vivid dreams**, **increased irritability**, or **mild avoidance behaviors** creeping in. For instance, an individual who had been freely driving again starts feeling a twinge of fear about driving on highways – that could be an early sign that anxiety is trying to resurface. Or maybe they notice **muscle tension** and frequent worry over minor issues, which were gone during remission. Teaching patients to self-monitor (perhaps keeping a light journal or using a mood/anxiety tracking app) can help catch these subtle increases. We tell them, "You know your pattern; if you start having those chest flutters more often or find yourself canceling plans due to anxiety, that's the time to check in with us."
Triggers in life: Often relapse can be precipitated by **external stressors** or **changes**. For example, a major life stress (loss of a loved one, job stress, another illness) can strain their coping and the anxiety might resurface. Also discontinuing treatment can be a trigger – e.g., if they stop their SSRI without taper or finish therapy and then face a stress without maintenance strategies. We identify known triggers: e.g., seasonal changes if they have patterns (some thyroid conditions fluctuate, or maybe they always had more anxiety in winter, etc.), or certain anniversaries. We warn them gently: "The holiday season is coming – that used to be a hard time for you. Let's be vigilant and maybe schedule a booster session around then."
Medical adherence issues: Missing medication for the medical condition can cause relapse. If a patient stops their thyroid pills, their condition can return and so will anxiety. So an early sign might be that they got lax on meds or follow-ups (maybe due to feeling well). We counsel them to keep up with all medical advice even when feeling good. If a patient has an erratic schedule and inadvertently misses doses (like of blood pressure meds or steroids) and then feels anxious, that's a clue. Thus, consistent adherence prevents relapse, and noticing any non-adherence or difficulty managing regimen is important. Family or caregivers can help here too by noticing if the patient is taking their meds or if prescriptions remain unfilled.
Decline in self-care or routine: If a patient had established good routines (exercise, sleep, etc.) and we see those falling by the wayside, that can precede relapse. For instance, they stop exercising for a few weeks and then anxiety starts to increase. Or they begin isolating again at home whereas they had been socializing. These behavioral changes often predate full symptom relapse. So staying engaged in healthy habits is both prevention and an

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	indicator – deviation from them could signal trouble. When early signs are detected, the plan is to act early: maybe the patient resumes therapy for a few booster sessions, or temporarily increases a medication dose (with doctor's guidance), or addresses the medical trigger (adjusting a med for the physical illness). For example, if thyroid labs show slight imbalance at an early stage, adjusting the dose prevents a full thyrotoxic state and anxiety flare. If life stress is building, using stress management techniques or brief counseling can prevent decompensation. We often create a **relapse prevention plan** with the patient at termination of treatment. This might list their personal warning signs (e.g., "trouble falling asleep three nights in a row, skipping meals, avoiding phone calls") and corresponding actions ("practice relaxation, call therapist if it persists a week, see doctor to rule out return of condition, tell my friend/spouse to help motivate me," etc.). The patient is advised to keep this plan handy. Some even schedule a "check-in" appointment a few months later as a safety net. With chronic conditions, we expect some fluctuations, so it's more about **early management** than preventing any uptick at all. But with cured conditions, ideally we catch any hint of return. Usually, patients become quite adept at knowing themselves – since they went through it once, they are often vigilant and will reach out quickly if they feel something is off. Educating them not to wait until it's severe is key: sometimes people feel they shouldn't bother the doctor until it's really bad; we explicitly tell them earlier is better (easier to treat, less suffering). In summary, early signs can be physical, psychological, behavioral, or external. Recognizing and addressing them can often nip a relapse in the bud, or at least reduce its intensity. We aim for the patient to eventually self-manage this process, with the care team as backup support.

Maintenance Treatment Options	For individuals at risk of recurrence (due to chronic underlying condition or past episodes), **maintenance strategies** are used to sustain remission: **Continued medications:** Depending on the scenario, a patient might stay on a low dose of an SSRI or other medication long-term to prevent relapse. For example, if an older patient has minor residual anxiety after a cardiac issue but is doing well on an SSRI, one might keep them on it for a year or more, given SSRIs are generally safe long-term. If the underlying medical condition is controlled but could flare (like autoimmune diseases), keeping anxiety meds on board can cushion any mild flares. On the flip side, if the medical condition is resolved and the patient has been anxiety-free for a good period, a trial of tapering off may be done to see if they can maintain without meds. But if anxiety symptoms return, resuming maintenance meds is an option. **Maintenance psychotherapy:** Some patients benefit from periodic therapy sessions even after acute treatment ends. For instance, a patient might come for a monthly "booster" CBT session or join a support group that meets regularly. This helps reinforce skills and provides a space to catch early signs. For chronic illness, sometimes **support groups** for that illness can serve maintenance by offering ongoing coping support (like a diabetes support group discussing how to handle anxiety over glucose swings). Others might not need continuous therapy but know they can return if needed. Teaching them to use self-help resources (books, online refreshers of CBT) is another maintenance tool. **Lifestyle maintenance:** Encouraging the patient to continue the healthy lifestyle habits adopted during treatment is critical. They should view exercise, good sleep, moderate stress, etc., not as a temporary "treatment" but as part of their ongoing life. We might formalize a wellness plan: e.g., "I will continue yoga twice a week, limit caffeine permanently, practice 10 min of meditation daily." These preventative habits maintain the gains. Some people find it helpful to keep using a mood/anxiety tracking journal or app for a while to ensure they stay on track. Others might regularly use relaxation recordings as part of routine. **Regular medical follow-ups:** Maintenance includes sticking to the schedule of medical check-ups for the underlying condition. For example, an individual with an adrenal tumor removed should go to all follow-ups to ensure no recurrence; someone with diabetes should keep regular A1c checks. These appointments can catch issues early. Additionally, knowing that their doctors are monitoring them can give the patient peace of mind, which in itself helps reduce anxiety. If the patient tends to worry between check-ups, sometimes we arrange for slightly more frequent check-ins initially until confidence grows. Having a good relationship with a primary care provider who can periodically assess overall health is invaluable in maintenance phase. **Contingency plan:** We often set a plan that if certain triggers happen, the patient will temporarily escalate care. For example, if they need to go on corticosteroids for some reason (which we know can trigger anxiety), we might preemptively schedule an extra therapy session or start a prophylactic low-dose anxiolytic during that period. Or if they become pregnant (hormonal changes), we plan how to monitor and manage any anxiety. Basically, maintaining remission may require adapting to new life events. If the patient knows to loop us in when such events occur, we can adjust quickly. This is particularly relevant

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	for those with chronic conditions that have flare-ups – the maintenance plan should include how to manage anxiety during flares (maybe having a small PRN script of lorazepam reserved for an asthma hospitalization, for instance, with instructions). As long as these are done carefully, it can prevent small episodes from becoming major ones. **Duration of maintenance:** This varies. For some, a 6-12 month continuation after remission is enough, then a careful taper is done. For others with ongoing triggers, maintenance may be indefinite (like someone with COPD might stay on an SSRI indefinitely to help with chronic anxiety related to breathing issues). We individualize. The decision to stop maintenance treatments is made collaboratively, considering factors like how stable the medical condition is, any upcoming stressors, and patient preference. If we stop, we do so gradually and with a plan to reinstate if needed. **Patient empowerment:** Ultimately, maintenance is about teaching the patient to self-manage – they become their own "therapist" in a sense, continuing the techniques learned, and monitoring themselves. We encourage a mindset that managing their health (physical and mental) is an ongoing process, but one they are equipped for. Routine – in medication, lifestyle, follow-ups – becomes their new normal. For many, this regime not only prevents relapse but improves overall quality of life because it fosters a healthier lifestyle. If maintenance efforts fail and relapse occurs, we then treat that actively and reinstate whichever treatments are needed; it's not a failure, just part of the journey. The patient should be made comfortable that needing help again is okay. But with a good maintenance plan, often patients can go very long or indefinitely without a full-blown recurrence, enjoying the benefits of their hard-won progress.

Prognostic Indicators (Good/ Poor)	Certain factors predict a more favorable outcome, and others signal more challenges: **Good Prognostic Indicators:** - *Identifiable and treatable cause:* If the underlying medical condition is clearly identified and can be cured or controlled (e.g., a benign thyroid nodule causing hyperthyroidism that is successfully ablated), prognosis for the anxiety is excellent [39] . Quick resolution of the physiological trigger usually leads to remission of anxiety. - *Early intervention:* Cases caught early in their course (before the patient develops severe avoidance or depression) tend to resolve faster and more completely [40] . The less time spent suffering, the less secondary consequences (like demoralization) to undo. - *Good insight and adherence:* Patients who understand the nature of their symptoms (that it's from a medical issue and that treatment will help) and who follow through with treatment recommendations (taking meds, engaging in therapy, managing lifestyle) do much better. They actively participate in their recovery, which usually brings faster improvement. - *Strong support system:* As discussed, having supportive family/friends and stable life circumstances (employment, housing) helps tremendously. It reduces external stress and aids the patient in focusing on recovery. Such patients often have someone to help encourage them and spot issues early, which improves outcomes. - *No or minimal psychiatric history:* If the person didn't have an underlying anxiety disorder or other mental illness prior to this, it's likely a pure case of "cause-treated = anxiety gone." They may not have the ingrained cognitive patterns of primary anxiety, so once the trigger is gone, they often return to baseline mental health. Contrast with someone who's been anxious their whole life – in them, a medical cause might amplify it and even after fixing it, some baseline anxiety might remain to address. - *Younger age (for recovery capacity):* Younger patients (child, adolescent, young adult) often bounce back quickly once treated. They typically have fewer chronic medical issues, and their brain's plasticity allows them to unlearn anxiety responses faster. That said, older patients can also recover well if cause is treated, but they might have more complicating health issues or slower adaptive responses. **Poor Prognostic Indicators:** - *Chronic or progressive medical condition:* If the cause is something that cannot be fully eradicated (like a neurodegenerative disease, severe COPD, chronic heart failure), the anxiety may continually be provoked by ongoing symptoms. We can manage it, but it might never fully remit. The prognosis is more about maintaining function and comfort rather than cure. Frequent relapses of the medical illness (e.g., recurring hyperthyroid episodes) also mean recurring anxiety episodes – making it an ongoing battle rather than a one-time fix. - *Delayed diagnosis or treatment:* If the person spent a long time misdiagnosed or untreated, they may have developed entrenched avoidance behaviors, conditioned fear of symptoms, or even secondary depression. For example, someone who had 5 years of unexplained tachycardia and panic before a pheochromocytoma was found may have meanwhile developed agoraphobia and lost their job. Even after curing the tumor, they might need extensive rehab (therapeutic and vocational) to rebuild their life. Longer untreated anxiety also can take longer to extinguish as habits and neural pathways have been reinforced over time. - *Co-morbid psychiatric conditions:* The presence of

another mental disorder (major depression, personality disorder such as borderline or dependent, or substance use disorder) can complicate and prolong treatment. For instance, if major depression is present, motivation can be low and symptoms like fatigue or poor concentration may linger even if anxiety improves. Personality disorders might interfere with the therapeutic relationship or adherence (like mistrust or dependency issues). These comorbidities often require their own targeted interventions, and improvement in anxiety may be partial until those are addressed.
- *Poor adherence or health behaviors:* Some patients have difficulty following through – maybe due to chaotic life, cognitive issues, or lack of trust in doctors. If they don't take medications regularly or quit therapy early, outcomes are worse. Similarly, continuing unhealthy behaviors (substance use, poor diet, etc.) will impede progress. Prognosis is less favorable if these factors can't be remedied.
- *Lack of support or high stress environment:* Patients isolated or in high-stress living situations (abusive relationship, financial crisis) have a tougher time recovering. Constant external stress can keep the anxiety response on even if the medical cause is fixed. Also, without support, they might not have help in emergencies or encouragement to persist in treatment. Their attention might be split between dealing with social issues and focusing on self-care, making recovery slower.
- *Severity and complexity:* The more severe the anxiety symptoms (e.g., panic attacks multiple times daily, significant functional impairment) and the more complex (involvement of multiple organ systems or multiple simultaneous causes), the more challenging to treat. For example, an elderly patient with diabetes, mild stroke, and COPD – each contributing a bit to anxiety – is more complex than a young patient with isolated hyperthyroid. Recovery might be only partial in the complex case (we manage each contributor but can't eliminate them fully). People with extremely severe anxiety might also require longer rehabilitation to overcome avoidance and regain confidence.
These indicators help guide expectations and planning. For instance, with poor prognostic signs, we might plan a longer treatment course, involve more multi-disciplinary team members (like social workers, rehab), and set more modest short-term goals. With good prognostic signs, we can be optimistic and perhaps more aggressive in short-term treatment expecting quick gains.
It's important to communicate to patients: prognostic indicators are general – every individual can defy expectations. We use them to shape care (for example, if someone has chronic illness, we emphasize adaptive coping as much as symptom elimination, and ensure ongoing support). They are not deterministic. Often, improvement is possible even in poorer prognosis cases, just maybe not 100% symptom elimination. We celebrate incremental improvements and focus on improving quality of life even if some anxiety remains. Many "poor prognosis" patients can still achieve a lot of progress with persistent, comprehensive care. The key is that these factors tell us where to bolster support. For example, knowing someone has no support (poor factor) prompts us to plug them into community resources right away to mitigate that.
Ultimately, prognosis is quite favorable for most when appropriate treatment is delivered – many patients either fully recover or can be managed to

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	have only mild occasional symptoms. Continual advances in both medical and psychological therapies are improving outcomes even further.

Typical Recovery Timeframes	The timeline for recovery can vary widely depending on cause and individual, but some general patterns: **Acute medical cause, quick treatment:** If the cause is rapidly treatable (e.g., removal of an offending drug or correction of a metabolic imbalance), improvement in anxiety can be seen in days to weeks. For example, treating a patient's hyperthyroidism with beta-blockers and antithyroid drugs often yields noticeable anxiety reduction within **a week or two** – palpitations lessen, sleep improves. Panic attacks might stop as soon as heart rate is controlled. Full normalization of thyroid levels might take a couple of months, but symptomatic relief typically precedes full lab normalization. Another example: a pheochromocytoma surgical removal – often, within **a few days post-op**, the patient's blood pressure and adrenaline levels normalize and they experience a dramatic calm compared to pre-surgery. Some residual anxiety might linger out of habit, but physiological panic is gone very quickly. So acute interventions can lead to partial recovery in days, substantial recovery in weeks, and near-full recovery within a couple of months. **Therapy and medication timeline:** If someone requires psychotherapy or psychiatric meds (like SSRIs) to relearn and readjust, that process usually unfolds over **several weeks to a few months**. SSRIs take ~4-6 weeks for significant effect (some improvement might be as early as 2 weeks, but robust changes by 6-8 weeks) [66] . Therapy (CBT) often is structured as ~10-12 weekly sessions, i.e., about 3 months, to achieve goals [76] . Many patients experience steady improvement across that period – for instance, by week 4 they report fewer panic attacks, by week 8 they're driving again, by week 12 they feel mostly back to normal aside from mild residual anxiety. So if we consider combined treatment, often around **3 months** one sees marked recovery (70-80% improvement). Those with milder symptoms might reach that in 6-8 weeks; those with more severe might take longer or need extended therapy (maybe 16 sessions, or a second medication trial if first med was ineffective). **Chronic conditions management:** If the underlying illness is chronic, "recovery" is more about achieving a stable state rather than a finite endpoint. One might say the patient reaches a good control of anxiety in maybe 3-6 months, but will need ongoing management. For example, someone with COPD might take a few months to adapt coping strategies and optimize medical therapy to where anxiety is minimal day-to-day. They might then be in maintenance mode indefinitely. Flare-ups could temporarily regress progress (a bad respiratory infection might cause a spike in anxiety for a week or two, then settle). Generally, initial improvement in a chronic scenario can still occur within weeks (like starting an SSRI and noticing less constant worry by one month), but full integration of coping and adjustments might be a 6-month project. If therapy is involved, sometimes it's spaced out over that period to allow practicing skills in real life. **Delayed improvement cases:** If the condition was longstanding before treatment, recovery might be gradual. Some patients continue to improve even after formal treatment ends. For instance, after stopping therapy at 3 months significantly better, they may find that over the next 6 months they continue to gain confidence and further reduce anxiety on their own (a continued upward trajectory as they re-engage with life). On the other hand, some might need a second phase of treatment – say initial improvement plateaued at 50%, then a

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	medication switch or additional therapy extends improvement over another couple of months. So outliers aside, most see major strides within 3 months and near-maximal improvement by **6 months** of proper treatment. If not, then we reassess strategy. **Return to functionality:** In terms of functional milestones: maybe out of work initially, a patient often can resume work or normal activities by about **2-3 months** in many cases if the cause is handled. For example, a teacher who took leave due to panic from arrhythmia might return next semester (a few months later) once pacemaker is in and therapy done. Social and leisure activities often resume earlier, as a stepping stone, within several weeks of feeling better. It's important to tailor expectations: we tell patients that improvement often starts in weeks, but *full* recovery may take a few months. We emphasize that this is normal and not to be discouraged if they're not 100% after a couple of weeks – as long as they see some trend in the right direction. When they do reach a stable recovery, we might keep treatments steady for a while before tapering anything (e.g., continue meds for 6-12 months even if fine at 3 months, to ensure stability). If all goes well, by the end of **one year** from initial diagnosis, many patients are off medications (if appropriate), out of therapy, and anxiety-free, only doing periodic check-ins and maintaining healthy habits. Some remain on maintenance meds or therapy beyond that, particularly if needed to prevent relapse. But a year is a good timeframe to consider someone likely fully recovered and just in follow-up mode. Of course, times vary – a mild case could be essentially done in a month, a complex case could need more than a year to sort everything out. But the majority, benefiting from combined interventions, improve significantly within the first few months and keep that momentum to recovery soon thereafter.

Recurrence Rates	**Recurrence (relapse) rates** depend largely on the course of the underlying medical condition and whether precipitating factors return: **If the medical condition is completely resolved** (e.g., tumor removed, hormone levels permanently stabilized), the recurrence of the anxiety disorder is relatively low – essentially, if the trigger is gone and stays gone, the anxiety should not come back. However, recurrence is possible if some underlying vulnerability remains or if another medical issue arises. For example, someone cured of one issue might later develop a different condition that again causes anxiety. But strictly for the same condition, if truly cured, one could consider the recurrence risk similar to their baseline risk of any anxiety (which in someone without prior issues is fairly low). One might estimate a low recurrence probability, perhaps **<20%** in such cases, primarily owing to other factors (like psychosocial stress) rather than the original cause. **Chronic or episodic medical conditions**: If the illness can flare or relapse, the anxiety will likely follow those patterns. For instance, **multiple sclerosis (MS)** can have flares; if an MS plaque previously caused anxiety symptoms, a new flare could do so again. Or **hyperthyroidism** due to Graves' disease might relapse if antibodies rise again – anxiety would recur in that event. Thus, recurrence rate in these is tied to disease activity; it could be say 50% if the disease commonly flares, or higher if flares are frequent. We try to mitigate by continued medical management (e.g., radioactive iodine for Graves might reduce recurrence vs medication alone). But realistically, patients with chronic conditions may experience multiple episodes of heightened anxiety across their life whenever their condition worsens. The "disorder" might be considered in remission between, and acute during flares. **Primary anxiety vulnerability**: If a patient had some innate tendency or concurrent primary anxiety, they might have recurrences even without the original medical trigger. Possibly the medical incident sensitized them to their body, and they might develop a primary panic disorder or health anxiety even after the trigger is gone. The recurrence rate in those individuals corresponds more to the typical relapse rate of anxiety disorders in general (which can be around 20-30% over several years after successful treatment, depending on the study). Good follow-up and booster sessions can reduce this. **Non-adherence or premature discontinuation**: One cause of recurrence is stopping treatment too early. For instance, discontinuing an SSRI right after feeling better might lead to relapse of anxiety in, say, a few months (sometimes even precipitating withdrawal anxiety that complicates things). To avoid this, guidelines often recommend continuing medication for at least 6-12 months after remission. If someone doesn't follow that, recurrence chances climb. Similarly, quitting therapy early (before skills are fully learned or before tackling all avoidance) can result in relapse under stress. It's hard to quantify, but anecdotal experience suggests if someone stops an SSRI after 3 months when recommended 12, they might have e.g. a 50% chance of symptoms returning versus maybe 20% if they'd stayed the full duration (these numbers are illustrative, actual depend on context). **Life stressors**: Even in a patient essentially "cured," major life stresses (divorce, loss, new illness) could precipitate anxiety again. That might be counted as a recurrence of the anxiety disorder, though it's due to new triggers (and possibly diagnosed as something

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	else like adjustment disorder depending on specifics). Life being unpredictable, one can't give a precise recurrence rate, but acknowledging that **everyone is vulnerable** to anxiety if stressors are big enough is important. For a person who had a pathological anxiety episode once, they may have a slight predisposition to react anxiously to future stress, so recurrence could be a bit more likely in the face of adversity compared to someone who never had that experience. But with their new skills, hopefully they manage it better if it arises. Statistically, since this is a niche diagnosis, exact recurrence rates aren't well documented in literature like they are for, say, major depression. We extrapolate from analogous conditions: For primary panic disorder, relapse rates after successful treatment are roughly 20-30% within 1-2 years (meaning majority maintain gains). For anxiety due to medical cause, if the cause remains under control, I would expect similar or better maintenance because the root is handled. If cause can relapse, then risk is tied to that – e.g., if a condition has a 50% relapse rate in five years, one could guess anxiety would relapse accordingly about 50% in that timeframe unless preventative measures are in place. Thus, in practice we do long-term follow-ups in a schedule appropriate for the medical issue. For a resolved issue, maybe a 6-month then 1-year follow-up to ensure no return. For chronic issues, ongoing regular check-ins. If after some years no anxiety has returned, one might consider it a closed chapter, but remain available. In any case, if recurrence happens, prognosis remains good that it can be controlled again – often quicker the second time because either the patient recognizes it sooner or treatment is resumed promptly. We encourage patients that a recurrence is not a failure, just an incident to address.

Patient Education Recommendations	Educating the patient (and family) is a continuous process. Key recommendations and info typically provided include: **Understanding the disorder:** We explain in clear, non-technical terms the link between their medical condition and anxiety symptoms. For example, “Your thyroid gland was producing too much hormone, which is like your body’s gas pedal being stuck – it revved everything up, including your nerves, making you feel anxious [23] . Now that we know that, we can treat the thyroid and the anxiety should ease.” We often use analogies (like “adrenaline rush” or “smoke alarm going off because of an electrical short – fix the wiring, the alarm stops”). Ensuring they know *it’s not their fault or weakness* – it’s a physical reaction – is crucial for reducing any shame. **Rationale for treatments:** We review why each component is recommended. E.g., “Beta-blockers will help by slowing your heart rate, so you don’t get those pounding heart feelings that scare you,” and “Therapy will teach you ways to cope with and lessen the anxiety while we treat the underlying problem, and give you tools for the future.” When prescribing SSRIs, we mention the expected timeline and that initial side effects may happen [73] . We also address any concerns – for instance, some are wary of psychiatric meds; we provide evidence of safety and how it’s a common part of treatment, and it can be temporary. For therapy, some might doubt its usefulness for a “medical” problem; we clarify it’s to help with the emotional component and to regain confidence and normal life. **Self-monitoring and triggers:** We teach them to be a detective of their own symptoms – recognizing early cues of anxiety, tracking what might provoke it. They might keep a simple log of symptoms and context, which we review to identify patterns. Education includes pointing out triggers like caffeine (“I know you love coffee, but as we saw, it’s making your heart race more – maybe decaf or one cup a day max is better [57] ”), or stress (“If you have a very busy day, plan short relaxation breaks to prevent overload”). We often hand out or recommend reading materials, like brochures on anxiety management or credible website resources (APA, ADAA, etc.) so they can educate themselves further outside sessions. **Lifestyle importance:** We reinforce things like sleep hygiene, diet, exercise with practical tips (some might not know what “sleep hygiene” entails). For example, give them a checklist: avoid screens 30 min before bed, keep consistent bedtime, limit naps, etc. For diet, maybe a list of high-caffeine foods to avoid, and suggestion of alternatives (herbal tea, water). If weight loss from anxiety happened, discuss small frequent meals to regain strength. If they smoke, counsel on smoking cessation (nicotine can both calm and stimulate – quitting smoking improves overall health and anxiety in long run). Essentially, equip them with knowledge that these daily choices make a difference in anxiety levels. **Emergency plan:** Educate what to do if severe symptoms occur. For instance, “If you ever feel the anxiety is escalating to a point where you think you might collapse or have suicidal thoughts, here’s how to reach me or emergency services.” If panic strikes, remind them of breathing techniques (“Breathe slow, remind yourself you’ve been checked out and your heart is okay, use your coping card if you have one”). If the underlying condition has specific emergency signs (like extremely high blood pressure in pheochromocytoma), teach them which signs mean get to ER vs which can be managed at home. This

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	prevents panic about panic – they know the plan. **Relapse prevention & follow-up:** As discussed, we educate them on what signs to watch for in future, and encourage continuing any maintenance strategies. Also encourage them to keep routine healthcare visits even when feeling fine – to monitor the condition (e.g., "Check your thyroid levels every 6 months for a while, just to be sure"). We emphasize that if anxiety or symptoms start creeping back, they shouldn't hesitate to reach out early. Normalize that needing a "refresher" therapy session or temporarily restarting a med is common and okay. Provide contact info and maybe a plan like "You'll have a follow-up with me in 3 months, but call sooner if needed." This reassurance helps them not feel abandoned after acute care. **Resources:** Give them resources like reputable books (e.g., "When Panic Attacks" by David Burns for CBT self-help), websites (like the Anxiety and Depression Association of America's patient info), or apps (Calm, Headspace, etc. for guided meditations). Also, if appropriate, information on their medical condition (patient handouts on hyperthyroidism, etc.) so they understand that too and can ask informed questions to their MDs. Sometimes knowledge reduces fear – e.g., reading that palpitations in hyperthyroid are common and improve with treatment might reduce catastrophic interpretations. Good patient education turns the patient into an active participant rather than a passive sufferer. They understand what's happening, why they're doing each step of treatment, and how to help themselves. This fosters adherence and confidence. It also demystifies the experience – a lot of anxiety comes from not knowing what's happening; knowledge replaces that unknown with something they can grasp. Many patients say, "Just knowing *why* I felt that way made me feel better already." We reinforce key points at multiple visits (people under stress might not absorb everything at once). Using simple language, visual aids (like showing how adrenaline works), or analogies improves comprehension. Ensuring family gets education too (with patient's permission) can help create a supportive environment. In summary: an educated patient is an empowered patient. By emphasizing the biology ("this is treatable and here's how") and the coping ("here's what you can do"), we reduce fear and set them up for success in overcoming the disorder and maintaining their gains.

Family Psychoeducation	Involving the family (or close significant others) can significantly improve outcomes. We provide them with tailored education and guidance such as: **Understanding the condition:** We explain to family members that the patient's anxiety symptoms are not voluntary or "all in their head" but are a real, biologically-driven reaction to a medical issue [23]. For instance, telling them, "Her adrenal gland was overactive, flooding her with adrenaline, so she was feeling intense panic – this is a physical cause." This helps generate empathy and patience. If family previously thought the patient should "just calm down," we correct that by highlighting it's as involuntary as a fever from infection – you can't will it away. We might share printed materials or analogies with them too, maybe in a family meeting or via patient if they prefer. **How to support vs. unintentionally reinforce:** Family may inadvertently do things that reinforce anxiety (for example, excessively reassuring or allowing the patient to avoid everything, which can maintain the cycle). We coach them on supportive behaviors: *accompanying* the patient to challenging but necessary situations but *not taking over their responsibilities entirely*. For instance, if the patient is afraid to drive, instead of the spouse always driving (which reinforces avoidance), we suggest the spouse encourage practice (perhaps ride along at first). We instruct on **gradual exposure support**: e.g., "Celebrate small victories with them, and don't push too hard too fast without therapist guidance." We also teach them **calming techniques** they can do together: maybe the family can practice breathing exercises with the patient, or help redirect them to use coping skills when anxious. Conversely, we advise against critical or dismissive comments ("stop being silly, there's nothing wrong") as that can worsen the patient's anxiety and alienation. Family should understand that anxiety isn't cured by logic alone, and phrases like "just relax" are not effective – instead, better to say "I'm here with you, let's breathe together." We might explicitly role-play with a spouse how to respond during a panic: speak slowly, remind the patient to breathe, maybe lightly touch their arm if that's comforting, etc. **Being part of the treatment team:** Family can help ensure medication adherence (maybe a partner can remind the patient to take meds if forgetfulness is an issue, or help refill prescriptions on time). They can also join in therapy for a session or two if needed – sometimes we have a spouse attend a CBT session to learn how to facilitate exposure exercises or to communicate about triggers. For example, a parent of an anxious teen might need to stop accommodating every avoidance; therapy can help them shift their approach. If the patient agrees, involving family in setting up the home environment for success is great – e.g., removing excessive caffeine from the home, or all agreeing to take nightly walks together for health. Additionally, if the patient's medical condition requires lifestyle changes (diet, exercise), family living in the same house could join in those changes (like cooking low-caffeine meals, or doing yoga together). This not only helps the patient stick to changes but might benefit the family's health too. **Awareness of relapse signs:** We educate family on what to watch for. In some cases, family notice changes before the patient does. For instance, a spouse might spot that the patient is becoming withdrawn or not sleeping well again, which could herald a relapse. We instruct them on those early signs (often similar to what we tell the patient, with patient's consent to share). And

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	importantly, we advise what to do if they see them – perhaps gently talk to the patient about returning to the doctor or therapist, rather than scolding them. Also, in terms of risk management, if the patient had any suicidal ideation or severe episodes, the family should know warning signs and emergency steps (e.g., if she says X or does Y, call the crisis line or take her to ER). That said, we also emphasize giving the patient autonomy as appropriate; family shouldn't become overbearing or treat the patient as incapable if not warranted, since that can hurt confidence. It's a balance – supportive vigilance without smothering. **Emotional support and self-care for family:** We encourage family members to be patient and listen to the patient's feelings without immediate judgment. Just being present and saying "I understand this is hard, but I believe you'll get through it and I'm here for you" is powerful. We also remind them to take care of themselves; supporting someone with anxiety can be stressful (for example, a spouse losing sleep because of patient's nighttime panic). They should ensure they're getting rest or breaks, and possibly seek their own counseling if needed to process their feelings (some may feel frustration, fear, etc.). If the family member is extremely anxious or overprotective, sometimes involving them in therapy to address *their* anxiety is helpful too – especially parent-child dynamics where a parent's anxiety can feed the child's. Overall, the goal of family psychoeducation is to turn the family into allies in the treatment process, to create a home environment conducive to recovery. When family knows what to expect (for instance, that medication might take a few weeks, or that exposure therapy might temporarily heighten anxiety), they can be more supportive rather than panicking or doubting the process. We find that outcomes are often better with a supportive family on board. It can also prevent conflict; for example, without education a spouse might resent "why aren't you better yet?" but with knowledge, they understand the timeline and complexity. This reduces strain on relationships. If family is not available or patient prefers not to involve them, then we might skip this, but often even a brief conversation with a key family member can have benefits. In clinic, giving family a handout or reading material (with patient's permission) can reinforce what we discuss. Many larger hospitals have **family education programs** or classes for mental health; though this being a specific condition, general anxiety disorder family resources still apply. We direct them to reputable websites or support groups for families if they exist (e.g., NAMI family groups, though those are more for serious mental illness, but some communities might have support for caregivers of chronically ill which could be relevant). In summary, **educating and enlisting family** can amplify treatment effectiveness and ensure the patient has continuous support beyond the clinic's walls.

Case Summary	**Case Example:** *John D., a 45-year-old male.* **Presenting Problem:** John was a healthy, full-time accountant with no psychiatric history. Over a span of two months, he began experiencing sudden episodes of intense anxiety. During these episodes, he felt his heart racing, chest pain, sweating, and an overwhelming fear that he might die. They occurred unpredictably, even waking him from sleep. Between attacks, he remained persistently nervous and on edge. He also noted unintended weight loss (~10 lbs), tremors in his hands, and feeling hot and flushed frequently. Initially, ER evaluations for chest pain/palpitations found no heart attack. He was told it was "probably anxiety" and was given alprazolam. While the alprazolam calmed him some, the attacks continued daily. John grew afraid to drive (he'd had an attack on the highway) and started missing work. He and his family felt something "medical" must be wrong because he was typically a calm guy until recently. **Evaluation & Diagnosis:** A thorough workup was done. His primary care physician ordered labs and found John's **thyroid function was abnormal**: very low TSH and high T3/T4 levels, indicating **hyperthyroidism**. Further tests revealed an enlarged thyroid (goiter) consistent with Graves' disease. This explained many of his symptoms. Simultaneously, a mental health evaluation confirmed that John's anxiety met criteria for *Anxiety Disorder Due to Another Medical Condition*, with the specific cause being hyperthyroidism (ICD-11 "Secondary anxiety syndrome", ICD-10 F06.4). John was relieved to have an explanation. **Intervention:** The treatment plan was two-pronged. First, an endocrinologist started John on **antithyroid medication (Methimazole)** to bring his thyroid levels down, and a **beta-blocker (Propranolol)** to immediately help with palpitations and tremors [37]. The beta-blocker also helped blunt the physical anxiety symptoms (heart pounding). Second, John began **Cognitive-Behavioral Therapy (CBT)** with a focus on panic symptoms. In therapy, he learned diaphragmatic breathing and relaxation techniques to use during panic attacks. He also worked on gradually driving again (initially with a friend, then short solo drives) to overcome his avoidance. The therapist helped him reinterpret symptoms – for example, reminding himself "It's my thyroid, not a heart attack; this feeling will pass." [79]. Education was given so he understood that as his thyroid normalized, these sensations would lessen. In addition, because SSRIs can treat anxiety and John's thyroid meds would take a few weeks to work, he was started on a low-dose **SSRI (Sertraline 25 mg)** with plans to increase to 50 mg as tolerated, to help manage generalized anxiety and support long-term recovery. He continued a small dose of alprazolam (0.25 mg) only if needed for extreme attacks, with instruction to try other skills first. **Outcome:** Within **3 weeks**, John noticed a significant drop in panic frequency. The beta-blocker had largely stopped the racing heart and sweating episodes. By 6 weeks, his thyroid levels were improving and he reported feeling "much calmer." He successfully drove to work and back without panic. In therapy, by week 8, he had resumed most normal activities. His GAD-7 anxiety score went from 16 (moderate) at intake down to 5 (minimal) at 8 weeks. At the 3-month mark, John felt **90% back to normal** – no spontaneous panic attacks, just occasional mild worry. He was weaning off alprazolam completely. Sertraline was continued for now. The diagnosis effectively resolved as his medical condition came under control. John's case

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	illustrates how treating the medical cause (hyperthyroidism) in conjunction with therapy leads to remission of "anxiety due to [that] medical condition." On follow-up 6 months later, John remained well: thyroid function was stable on medication, and he had tapered off sertraline with no return of significant anxiety. He returned to his full duties at work and his quality of life was restored. [39] [80]
Presenting Problem	**Presenting Problem:** John presented with sudden onset of **severe panic attacks** and continuous anxiety over a two-month period. He described episodes of intense fear ("like I'm about to die") accompanied by **palpitations, chest pain, sweating, trembling, and shortness of breath**, often occurring out of the blue (even waking him at night). Between attacks, he felt jittery and unable to relax. He also noted **unexplained weight loss**, heat intolerance (feeling unusually warm), and hand tremors. Initially, he sought emergency care for what he thought were heart attacks; cardiac tests were normal. This led to a referral for evaluation of anxiety. At intake, John's chief complaint was: "I have these terrifying panic attacks every day and I don't know why. I've become afraid to do anything – I even quit driving. I'm constantly on edge." He had no prior psychiatric history and was puzzled by the new onset of symptoms in his mid-40s. His distress was high and it was impairing his ability to work and drive, prompting comprehensive assessment.

Intervention	**Intervention:** Treatment targeted both John's medical condition and his anxiety symptoms. Key interventions included: - **Medical management of hyperthyroidism:** An endocrinologist started John on **Methimazole**, an antithyroid medication to reduce thyroid hormone production. Additionally, a **beta-blocker (Propranolol)** was prescribed to control physical symptoms like rapid heart rate, high blood pressure, and tremors [37]. Propranolol helped immediately to diminish the intensity of palpitations and sweating, which in turn reduced John's panic intensity. John's primary care doctor coordinated with the endocrinologist, and John had blood tests every 2-3 weeks to monitor thyroid levels and adjust the Methimazole dose. The plan was to continue antithyroid medication for 12-18 months (standard for Graves' disease) and consider definitive treatment if needed. - **Psychopharmacology for anxiety:** To address persistent anxiety and prevent attacks while the thyroid treatment took effect, John's psychiatrist initiated **Sertraline (Zoloft)** at a low dose of 25 mg/day, aiming to titrate to 50 mg/day after one week. Sertraline, an SSRI, was chosen for its anti-panic and anti-anxiety efficacy and relatively favorable side effect profile [64]. John was educated that it would take a few weeks to work. In the interim, his doctor provided a small supply of **Alprazolam (Xanax)** 0.25 mg, to use *only if* he had an unbearable panic episode. This was a safety net, with the understanding that reliance on it should decrease as other treatments kicked in. The psychiatrist emphasized using non-pharm skills first (like breathing exercises) and reserved alprazolam for acute situations. The goal was to taper and discontinue alprazolam after a few weeks, to avoid dependence. - **Cognitive-Behavioral Therapy (CBT):** John began weekly sessions with a clinical psychologist. In therapy, they used CBT techniques: **Psychoeducation** was first – John learned how excess thyroid hormone was fueling his fight-or-flight response, and how panic attacks work (the cycle of physical sensations -> catastrophic interpretation -> increased panic). Understanding this helped reduce his fear of the attacks [80]. **Breathing and relaxation skills** were taught; John practiced slow diaphragmatic breathing and progressive muscle relaxation in session and at home, which he could use at the first sign of panic. **Cognitive restructuring** addressed John's catastrophic thoughts ("I'm dying" or "I'll lose control") by examining the evidence (he had medical clearance that his heart was fine, etc.) and coming up with rational responses ("This is a panic feeling caused by my thyroid; it will pass and I will be okay"). The therapist had John keep a log of panic episodes, noting triggers, symptoms, thoughts, and how he coped, then reviewed it to reinforce improvements. **Exposure therapy** was also employed for avoidance behaviors: since John had stopped driving on highways, the therapist created a graduated exposure hierarchy. First, John practiced sitting in a parked car using relaxation techniques. Next, he drove short distances on a quiet street with his wife. Then he merged onto a highway for one exit and off, and gradually increased duration. Over a few weeks, he regained confidence in driving without panic. The therapist also simulated some physical symptoms (having John spin in a chair to get mildly dizzy, do a few jumping jacks to raise heart rate) within session to practice tolerating those without freaking out – a method of interoceptive exposure. With repeated practice, John's fear of bodily sensations reduced. - **Lifestyle adjustments:**

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	John made several changes per his providers' recommendations. He eliminated caffeine (switched to decaf coffee) to avoid compounding palpitations [57] . He adopted a consistent sleep schedule and began doing light exercise (walking in evenings) once his doctor cleared him, to help manage stress and improve sleep. His wife was involved in some sessions and learned how to support him – for instance, by doing the breathing exercises together and not inadvertently reinforcing avoidance (she stopped doing all the driving for him and instead encouraged him on gradual exposures). Throughout, there was close collaboration: the psychiatrist and therapist communicated about John's progress, and the medical doctors kept the team updated on thyroid levels. This integrated approach ensured John had comprehensive care.

Outcome	**Outcome:** John responded very well to the combined interventions. **Physiologically**, as early as two weeks into treatment, John's most frightening symptoms subsided: on propranolol, he no longer experienced sudden pounding heart episodes or surges of intense sweating. This in itself markedly decreased his panic frequency and intensity – the physical "waves" triggering panic had been tamed. By one month, his thyroid hormone levels had dropped towards normal range (and TSH was starting to rise), correlating with John feeling much calmer overall. He noted only mild residual tremors. The Methimazole was continued to drive his thyroid function fully into normal limits over subsequent months. **Psychologically**, by the 4-6 week mark, John reported a significant reduction in daily anxiety. The Sertraline, which he increased to 50 mg as planned, likely contributed: he mentioned that by week 4 he was waking up without a knot of anxiety in his stomach, a change he attributed to "the medicine starting to work." He tolerated Sertraline with minimal side effects – just a bit of nausea the first week which resolved [72]. He did not feel the need to use any alprazolam after the first couple of weeks, and he discontinued it entirely by week 6. In therapy, John was an engaged participant and diligently practiced his homework. Over ~10 CBT sessions, he achieved his goals: he returned to driving on the highway to commute to work by week 8, initially with some anxiety but using breathing techniques and not panicking. By week 12 (3 months in), he reported **no full panic attacks at all in the past month**. His baseline anxiety was only slightly higher than normal – he said "I feel a little more alert than I used to, but not in a bad way." On a scale, he rated his average daily anxiety as 2/10, whereas it had been 8/10 at intake. His sleep was restored, and weight stabilized. **Functionally**, John was back to working full-time; his productivity and concentration improved as his anxiety resolved. He resumed social activities he'd been avoiding – for instance, he went to a crowded baseball game with his family with only minimal anxiety (and that he managed with techniques). His family noted he was "back to his old self," joking and not preoccupied with worry. They were impressed with how quickly the worst passed once treatment began. At a **6-month follow-up**, John remained euthyroid (proper thyroid levels) on Methimazole. The plan was to continue it for a total of a year then reassess if he could taper off. He stayed on Sertraline for maintenance, with psychiatrist agreement to possibly trial tapering it after his thyroid was completely treated and stable for a while. He continued doing occasional therapy booster sessions once a month for a couple more months, then transitioned to "as-needed" visits. He had not had any panic attacks since month 2 of treatment. He did have one or two mild anxiety episodes (for example, when he had to give a big presentation at work) but he effectively managed those with the skills he learned (and a single propranolol dose pre-presentation as advised). There were no safety issues; John denied any suicidal ideation (in fact, by follow-up he expressed feeling very hopeful and grateful, a big shift from the desperation he felt initially) [74]. Overall, John's case had an excellent outcome: the anxiety disorder remitted fully once the underlying hyperthyroidism was controlled and he gained tools to handle stress. This outcome is characteristic for treatable causes – remove the cause, and the anxiety can disappear. John and his providers remain vigilant for the

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	future; he knows to monitor his thyroid and to reach out if symptoms recur, but armed with knowledge and coping strategies, he is confident in handling his health going forward.

Direct Text Quotes	**ICD-11 CDDR (2024) – Essential Features of Secondary Anxiety:** "The presence of prominent anxiety symptoms (e.g. excessive worry, intense fear that is out of proportion to actual danger, panic attacks) is required for diagnosis... The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings (as opposed to being a psychological reaction to having the medical condition)... The symptoms are not better accounted for by delirium, dementia, another mental disorder... or the effects of a medication or substance... The symptoms are sufficiently severe to be a specific focus of clinical attention." [81] [10] *(ICD-11 clearly stipulates that anxiety must result from a physiological medical effect, and not merely coincide with or be psychologically about the illness.)* **ICD-10 (WHO, 1992) – Organic Anxiety Disorder Definition:** "A disorder characterized by the essential descriptive features of a generalized anxiety disorder (F41.1), a panic disorder (F41.0), or a combination of both, but arising as a consequence of an organic disorder." [5] *(ICD-10 described this as anxiety symptoms identical to primary anxiety disorders, yet caused by a "known physiological condition.")* **DSM-5 (APA, 2013) – Diagnostic Criteria:** *A.* "Panic attacks or anxiety is predominant in the clinical picture." *B.* "There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition." *C.* "The disturbance is not better explained by another mental disorder." *D.* "The disturbance does not occur exclusively during the course of a delirium." *E.* "The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." [12] [82] *(These DSM-5 criteria closely mirror the ICD guidelines, ensuring the anxiety is directly due to a medical condition and not accounted for by other causes.)* **PsychCentral (2022) – Explanation in Lay Terms:** "Anxiety disorder due to a medical condition occurs when a medical condition causes extreme fear, anxiety, or panic. If you have anxiety or worry about your medical condition, this is not considered an anxiety disorder. This diagnosis is used only if anxiety and panic symptoms are present due to your medical condition. An example of this would be if you began to experience panic attacks due to your diagnosed thyroid disease." [83] [84] *(This quote clarifies the distinction between anxiety* caused by *the physiological effects of an illness vs. understandable worry* about *having an illness, and gives a concrete example.)* **Theravive (n.d.) – Differential Diagnosis Note:** "There must be a close association between the medical condition and anxiety in order for this diagnosis to be appropriate... If the features of anxiety that are seen are not typical for a primary anxiety disorder, and there is a medical condition present, this is an indication that anxiety due to another medical condition may be an appropriate diagnosis." [4] [79] *(Emphasizes evaluating the timing and nature of anxiety symptoms relative to the medical illness to justify this diagnosis.)* **ICD-11 CDDR – Boundaries (Psychological vs. Physiological):** "Anxiety symptoms can occur as part of a psychological response to being diagnosed with or having to cope with a severe medical condition. In the absence of evidence of a physiological link between the medical condition and the anxiety symptoms, a diagnosis of secondary anxiety syndrome is not warranted. Instead, the appropriate mental disorder

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	can be diagnosed (e.g. an anxiety or fear-related disorder, adjustment disorder, hypochondriasis)." [18] [85] *(This delineates that if anxiety is purely a stress reaction to illness (no direct physiological cause), it should be classified differently, reinforcing the need for a direct pathophysiological link for this diagnosis.)* **ICD-11 CDDR – Examples of Medical Causes:** "Brain disorders and general medical conditions that have been shown to be capable of producing anxiety syndromes include: diseases of the nervous system (e.g. encephalitis, seizures); diseases of the circulatory system (e.g. cardiac arrhythmia, congestive heart failure… pulmonary embolism); diseases of the respiratory system (e.g. asthma, COPD); endocrine, nutritional or metabolic diseases (e.g. hyperadrenalism, hypercalcaemia, hyperthyroidism, hypoglycaemia…); neoplasms (e.g. malignant phaeochromocytoma of adrenal gland…)." [86] [87] *(Lists categories of illnesses known to provoke anxiety via physiological pathways, illustrating the wide range of potential causes.)* **APA Text (2013) – Suicide Risk Advisory:** "It is important for therapists working with patients suffering anxiety symptoms to keep in mind the possibility of suicide if the anxiety becomes severe." [88] *(Reminds clinicians that even though anxiety disorders are not primarily mood disorders, high anxiety can lead to suicidal ideation, so risk assessment is crucial.)*
Page Numbers	**Page References:** In the ICD-11 CDDR (Clinical Descriptions & Diagnostic Requirements) 2024 manual, the section on Secondary Anxiety Syndrome is found on **pages 663-665** [89] [90]. The DSM-5 description for "Anxiety Disorder Due to Another Medical Condition" appears in the Anxiety Disorders chapter, which in the DSM-5 hardcover is around **page 222-223** (APA 2013) [7]. The PsychCentral summary quoted above is an online article (2022) with no fixed pages but corresponds to DSM-5 content. The example from Theravive is a web article summarizing DSM-5 (no page, but it cites DSM-5, p. 222). ICD-10's definition can be found in the ICD-10 "Blue Book" under code F06.4 on **page 37** of the Organic Mental Disorders section [5]. *(Note: DSM-5 page numbers are approximate as per DSM-5 text; ICD-11 CDDR pages are given from the WHO 2024 publication. Direct quotes above include reference locators for verification.)*

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Editor/Author Notes	**Editor/Author Commentary:** The sources collectively stress the importance of discerning true physiological causes of anxiety versus other forms. The ICD-11 editors highlight the need for evidence of a direct pathophysiological link – essentially raising the diagnostic bar to prevent mislabeling general stress as "due to medical condition." They also expanded the list of medical examples, reflecting updated knowledge (e.g., including COPD, vitamin deficiencies). DSM-5's authors kept criteria similar to DSM-IV, underscoring consistency in this category across editions. One note by DSM-5 editors (APA, 2013) is that this diagnosis should be specified with the name of the medical condition (to encourage clinicians to seek and state the cause). Both ICD-11 and DSM-5 authors intended this category to be used only when *truly applicable*, and they caution clinicians not to overuse it when anxiety might be better explained by primary anxiety disorders or adjustment disorders. In practice, this means authors/editors want us to do due diligence with medical workups. From a clinical standpoint, authors like those of the ICD-11 CDDR emphasize differentiating psychological vs. physiological anxiety – an editorial point likely to reduce over-diagnosis of this category. They also note that if a patient's anxiety far exceeds what is typical for their condition, even if the condition can cause some anxiety, consider dual diagnoses (e.g., substance-induced or primary anxiety co-occurring) [91] . The experts uniformly advocate an integrated treatment approach: treat the medical cause and provide symptomatic relief. The inclusion of this disorder in both DSM and ICD indicates editors recognize the clinical reality that some anxiety is essentially a symptom of medical issues – and treating it improves outcomes in holistic patient care. In summary, the editors' notes and approach signal: "Don't diagnose this unless you have a medical cause – but if you do, treat both the cause and the anxiety, and educate the patient."

Contrasts With Other Sources

Contrasts & Comparisons: The various sources (ICD-11 vs. DSM-5 vs. ICD-10 vs. clinical commentary) are largely consistent in substance, with some differences in terminology and emphasis: **ICD-11 vs DSM-5:** ICD-11 uses the term *"Secondary anxiety syndrome"* whereas DSM-5 calls it *"Anxiety Disorder Due to Another Medical Condition."* Terminology aside, both require a causal medical factor. ICD-11 provides more explicit guidance on excluding psychological-only reactions (emphasizing not to code this if it's just stress about illness) [18] . DSM-5 implicitly says the same but in briefer criteria form. Another difference: DSM-5 (2013) placed this in the Anxiety Disorders chapter under code 293.84, and suggests specifying the medical condition; ICD-11 places it under "Secondary" syndromes with code 6E63 and encourages coding the medical condition alongside as a cluster. Essentially, ICD-11 formalized the linkage with the medical condition via coding, whereas DSM relies on descriptive specifier.
ICD-10 vs. newer versions: ICD-10's concept *"Organic anxiety disorder (F06.4)"* is directly carried forward into ICD-11's secondary anxiety. One difference is ICD-10 categorized it among "organic mental disorders," implying a broad inclusion of any brain/physical cause including brain injury. ICD-11 similarly includes it but updated the language (secondary to disorders elsewhere). ICD-10's definition specifically mentions it can look like GAD or panic or both [5] , whereas ICD-11 and DSM-5 also allow for any form of anxiety (including OCD-like if relevant, though OCD symptoms get categorized separately typically). The core idea remained same. ICD-11 provides more detailed guidance (like listing differential boundaries and examples) than ICD-10 did. This reflects how the understanding has been refined – ICD-11 editors clearly delineate conditions like delirium, adjustment, etc., which ICD-10 didn't elaborate in that short definition. So ICD-11 is more user-friendly for clinicians in that regard.
Clinical sources (Theravive/PsychCentral) vs formal criteria: The clinical summaries put criteria into plain language and emphasize practical points. For instance, PsychCentral explicitly states worrying about your medical condition doesn't count, only direct effects do [80] – which aligns with ICD's caution about psychological responses vs physiological cause. Theravive notes the need for close association in time between medical condition changes and anxiety onset [92] , which is basically rephrasing the temporal criterion ICD and DSM mention. These sources tend to include treatment advice – e.g., Theravive discusses treatment and prognosis, whereas the formal manuals do not. One could say the manuals focus on definition and diagnosis, while clinician-oriented sources integrate the next steps and context. There's no contradiction; the latter just expand on implications (like stressing careful medical evaluation [93] , which the DSM criteria assume but don't explicitly explain).
Emphasis on examples and prevalence: ICD-11 text and PsychCentral both give examples (thyroid disease causing panic). ICD gives a range of examples to guide clinicians (covering endocrine, cardio, etc.) [86] , which DSM-5 doesn't list explicitly in criteria (though DSM-5's text mentions some common causes such as hyperthyroidism, pheochromocytoma as footnotes or text discussion). The presence of such lists in ICD-11 suggests an effort to broaden clinician awareness of potential causes. PsychCentral's approachable style doing the same shows consistency in what examples are

Disorder Name	Anxiety Disorder Due to Another Medical Condition. *(Also known as "Secondary anxiety syndrome" in ICD-11 and formerly "Organic anxiety disorder" in ICD-10)* [1]
	well-known (thyroid being a classic one to mention). This alignment indicates consensus across sources on typical culprits. Meanwhile, ICD-10 didn't list examples in definition, which perhaps left more to clinician knowledge at the time; it relied on the term "organic" as a cue to search for any brain/body pathology. **Approach to treatment in sources:** DSM and ICD criteria sets don't cover treatment, but the commentary from sources like Theravive or APA publications highlights integrated treatment. There's agreement that treating the underlying condition is primary (Theravive: "treatment of anxiety may have to be postponed until the underlying condition is treated... often can treat both simultaneously" [94]). That notion is echoed across clinical guidance. Where we see slight variations is maybe in the order or specific interventions. For example, APA texts might emphasize psychotherapy plus appropriate meds, whereas an endocrinology article might emphasize medical treatment first. But ultimately all credible sources say both medical and psychiatric management are necessary. There's no conflict, just differences in focus depending on the source's audience (psychiatric vs general medical). In this report, I integrated those for completeness. **In summary,** the sources all converge on key points: a distinct disorder when anxiety is directly caused by a medical problem, requiring evidence and exclusion of other explanations. ICD-11 provides a more detailed blueprint (differentials and examples) than DSM's brief criteria, but they're complementary. Clinical summaries rephrase those formal criteria in more digestible terms and reinforce proper approach (like not missing a medical cause or misdiagnosing normal worry as this disorder). There is little contradiction – more so a difference in depth and guidance provided. It's apparent that modern classifications (DSM-5, ICD-11) have very similar constructs for this disorder, whereas older ICD-10 used "organic" terminology but meant the same idea. This consistency across sources strengthens the validity of the concept and ensures that whether a clinician picks up DSM or ICD or a clinical handbook, they'll get a consistent message on how to diagnose and handle Anxiety Disorder Due to Another Medical Condition.

[1] [2] [9] [15] [30] [32] [33] 6E63 Secondary anxiety syndrome - ICD-11 MMS
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[3] [6] [8] [10] [11] [18] [19] [20] [21] [22] [34] [61] [78] [81] [85] [86] [87] [89] [90] [91] CDDR.pdf
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[4] [16] [17] [24] [28] [29] [31] [40] [41] [42] [43] [44] [45] [46] [47] [48] [49] [50] [57] [64] [65] [66] [67] [68] [69] [74] [75] [76] [77] [79] [88] [92] [93] [94] Anxiety Disorder Due To Another Medical Condition DSM-5 293.84 (ICD-10-CM Multiple Codes) - Therapedia
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