

**University of Baghdad/ College of Nursing  
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## **7. Anxiety**

### **Definition**

Anxiety is a vague feeling of dread or apprehension; it is a response to external or internal stimuli that can have behavioral, emotional, cognitive, and physical symptoms. Anxiety is distinguished from **fear**, which is feeling afraid or threatened by a clearly identifiable external stimulus that represents danger to the person. Anxiety is unavoidable in life and can serve many positive functions such as motivating the person to take action to solve a problem or to resolve a crisis. It is considered normal when it is appropriate to the situation and dissolves when the situation has been resolved.

**Anxiety disorders** include a group of conditions that share a key feature of excessive anxiety with following behavioral, emotional, cognitive, and physiologic responses. Clients suffering from anxiety disorders can demonstrate unusual behaviors such as:

- Panic without reason,
- Unjustified fear of objects or life conditions,
- Uncontrollable repetitive actions,
- Re-experiencing of traumatic events, or
- Unexplainable or overwhelming worry.

They experience significant distress over time, and the disorder significantly impairs their daily routines, social lives, and occupational functioning.

### **Etiology (Causes)**

#### **1. Biologic Theories**

##### ***A. Genetic Theories***

- Anxiety may have an inherited component because first-degree relatives of clients with increased anxiety have higher rates of developing anxiety. *Heritability* refers to the proportion of a disorder that can be attributed to genetic factors:

- High heritability is greater than 0.6 and indicate that genetic influences dominate.
- Moderate heritability is 0.3 to 0.5 and suggests an even greater influence of genetic and non-genetic factors.
- Heritability less than 0.3 means that genetics are small as a primary cause of the disorder.

- Panic disorder and social and specific phobias, including agoraphobia, have moderate heritability.

- GAD and OCD tend to be more common in families, indicating a strong genetic component, but still require further in depth study.

##### ***B. Neurochemical Theories***

- Gamma-aminobutyric acid (GABA) is the amino acid neurotransmitter believed to be dysfunctional in anxiety disorders. GABA, an inhibitory neurotransmitter, functions as the body's natural antianxiety agent by reducing cell excitability, thus decreasing the rate of neuronal firing. Because GABA reduces anxiety and norepinephrine increases it, researchers believe that a problem with the regulation of these neurotransmitters occurs in anxiety disorders.

- Serotonin, the indolamine (monoamine) neurotransmitter usually implicated in psychosis and mood disorders, has many subtypes. 5-Hydroxytryptamine type 1a plays a role in anxiety, and it also affects aggression and mood. Serotonin is believed to play a distinct role in OCD, panic

disorder, and GAD. An excess of norepinephrine is suspected in panic disorder, GAD, and posttraumatic stress disorder.

## **2. Psychodynamic Theories**

### **A. Intrapsychic / Psychoanalytic Theories**

- Freud (1936) saw a person's distinctive anxiety as the stimulus for behavior. He described defense mechanisms as the human's attempt to control awareness of and to reduce anxiety.

**Defense mechanisms** are cognitive distortions that a person uses unconsciously to maintain a sense of being in control of a situation, to lessen discomfort, and to deal with stress. Because defense mechanisms arise from the unconscious, the person is unaware of using them. Some people overuse defense mechanisms, which stops them from learning a variety of appropriate methods to resolve anxiety-producing situations. The dependence on one or two defense mechanisms also can inhibit emotional growth, lead to poor problem-solving skills, and create difficulty with relationships.

### **B. Interpersonal Theory**

- Harry Stack Sullivan (1952) viewed anxiety as being generated from problems in *interpersonal relationships*. Caregivers can communicate anxiety to infants or children through inadequate development, agitation when holding or handling the child, and distorted messages. Such communicated anxiety can result in dysfunction such as failure to achieve age-appropriate developmental tasks. In adults, anxiety arises from the person's need to conform to the norms and values of his or her cultural group. The higher the level of anxiety, the lower the ability to communicate and to solve problems and the greater the chance for anxiety disorders to develop.

- Hildegard Peplau (1952) understood that humans exist in interpersonal and physiologic realms; thus, the nurse can better help the client to achieve health by attending to both areas. She identified the four levels of anxiety and developed nursing interventions and interpersonal communication techniques based on Sullivan's interpersonal view of anxiety. Nurses today use Peplau's interpersonal therapeutic communication techniques to develop and to nurture the nurse-client relationship and to apply the nursing process.

### **C. Behavioral Theory**

Behavioral theorists view anxiety as being learned through experiences. Conversely, people can change or "unlearn" behaviors through new experiences. Behaviorists believe that people can modify maladaptive behaviors without gaining insight into their causes. They struggle that disturbing behaviors that develop and interfere with a person's life can

### **Cultural Considerations**

Each Culture Has Rules Governing the Appropriate ways to express and deal with anxiety. Culturally competent nurses should be aware of them while being careful not to stereotype clients. People from Asian cultures often express anxiety through somatic symptoms such as headaches, backaches, fatigue, dizziness, and stomach problems. In some Hispanics during cases of high anxiety, sadness, agitation, weight loss, weakness, and heart rate changes. The symptoms are believed to occur because supernatural spirits or bad air from dangerous places and cemeteries invades the body.

### **Anxiety as a Response to Stress**

- **Stress** is the wear and tear that life causes on the body. It occurs when a person has difficulty dealing with life situations, problems, and goals.

- Each person handles stress differently: One person can thrive in a situation that creates great distress for another.

- For example, many people view public speaking as scary, but for teachers and actors, it is an everyday, enjoyable experience. Marriage, children, airplanes, snakes, a new job, a new school, and leaving home are examples of stress-causing events.

**- Three stages of reaction to stress:**

- In the ***alarm reaction stage***, stress stimulates the body to send messages from the hypothalamus to the glands (such as the adrenal gland, to send out adrenaline and to reconvert glycogen stores to glucose for food) to prepare for potential defense needs.
- In the ***resistance stage***, the digestive system reduces function to shunt blood to areas needed for defense. The lungs take in more air, and the heart beats faster and harder so it can circulate this highly oxygenated and highly nourished blood to the muscles to defend the body by fight, flight, or freeze behaviors. If the person adapts to the stress, the body responses relax, and the gland, organ, and systemic responses decrease.
- The ***exhaustion stage*** occurs when the person has responded negatively to anxiety and stress: body stores are exhausted or the emotional components are not resolved, resulting in continual arousal of the physiologic responses and little reserve capacity.

- Autonomic nervous system responses to fear and anxiety generate the involuntary activities of the body that are involved in self-preservation. Sympathetic nerve fibers “charge up” the vital signs at any hint of danger to prepare the body’s defenses. The adrenal glands release adrenalin (epinephrine), which causes the body to take in more oxygen, dilate the pupils, and increase arterial pressure and heart rate while constricting the peripheral vessels and shunting blood from the gastrointestinal and reproductive systems and increasing glycogenolysis to free glucose for fuel for the heart, muscles, and central nervous system. When the danger has passed, parasympathetic nerve fibers reverse this process and return the body to normal operating conditions until the next sign of threat reactivates the sympathetic responses.

- Anxiety causes uncomfortable cognitive, psychomotor, and physiologic responses, such as difficulty with logical thought, increasingly agitated motor activity, and elevated vital signs. To reduce these uncomfortable feelings, the person tries to reduce the level of discomfort by implementing new adaptive behaviors or defense mechanisms. Adaptive behaviors can be positive and help the person to learn, for example, using imagery techniques to refocus attention on a pleasant scene, practicing sequential relaxation of the body from head to toe, and breathing slowly and steadily to reduce muscle tension and vital signs. Negative responses to anxiety can result in maladaptive behaviors such as tension headaches, pain syndromes, and stress-related responses that reduce the efficiency of the immune system.

- People can communicate anxiety to others both verbally and nonverbally. If someone screams “fire,” others around them can become anxious as they picture a fire and the possible threat that represents. Viewing a worried mother searching for her lost child in a shopping mall can cause anxiety in others as they imagine the panic she is experiencing. They can convey anxiety nonverbally through empathy, which is the sense of walking in another person’s shoes for a moment in time.

Examples of nonverbal empathetic communication are when the family of a client undergoing surgery can tell from the physician’s body language that their loved one has died, when the nurse reads a plea for help in a client’s eyes, or when a person feels the tension in a room where two people have been arguing and are now not speaking to each other.

**\* Working with Anxious Clients**

- Nurses encounter anxious clients and families in a wide variety of situations such as before surgery and in emergency departments, intensive care units, offices, and clinics. First and foremost,

the nurse must assess the person's anxiety level because that determines what interventions are likely to be effective.

- **Mild anxiety** is an asset (Benefit) to the client and requires no direct intervention. People with mild anxiety can learn and solve problems and are even eager for information. Teaching can be very effective when the client is mildly anxious.

- **In moderate anxiety**, the nurse must be certain that the client is following what the nurse is saying. The client's attention can wander, and he or she may have some difficulty concentrating over time. Speaking in short, simple, and easy- to-understand sentences is effective; the nurse must stop to ensure that the client is still taking in information correctly. The nurse may need to redirect the client back to the topic if the client goes off on an unrelated line.

- **When anxiety becomes severe**, the client no longer can pay attention or take in information. The nurse's goal must be to lower the person's anxiety level to moderate or mild before proceeding with anything else. It is also essential to remain with the person because anxiety is likely to worsen if he or she is left alone. Talking to the client in a low, calm, and soothing voice can help. If the person cannot sit still, walking with him or her while talking can be effective.

What the nurse talks about matters less than how he or she says the words. Helping the person to take deep even breaths can help lower anxiety.

- **During panic-level anxiety**, the person's safety is the primary concern. He or she cannot perceive potential harm and may have no capacity for rational thought. The nurse must keep talking to the person in a comforting manner, even though the client cannot process what the nurse is saying. Going to a small, quiet, and non-stimulating environment may help to reduce anxiety. The nurse can reassure the person that this is anxiety, that it will pass, and that he or she is in a safe place. The nurse should remain with the client until the panic recedes. Panic-level anxiety is not continued indefinitely but can last from 5-30 minutes.

### Levels of Anxiety

	Psychological Responses	Physiologic Responses
<b>Mild</b>	<ul style="list-style-type: none"> <li>- Wide perceptual field</li> <li>- Sharpened senses</li> <li>- Increased motivation</li> <li>- Effective problem-solving</li> <li>- Increased learning ability - Irritability</li> </ul>	<ul style="list-style-type: none"> <li>- Restlessness</li> <li>- Fidgeting</li> <li>- GI "butterflies"</li> <li>- Difficulty sleeping</li> <li>- Hypersensitivity to noise</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>- Perceptual field narrowed to immediate task</li> <li>- Selectively attentive</li> <li>- Cannot connect thoughts or events independently</li> <li>- Increased use of automatisms</li> </ul>	<ul style="list-style-type: none"> <li>- Muscle tension - Diaphoresis</li> <li>- Pounding pulse</li> <li>- Headache - Dry mouth - GI upset</li> <li>- High voice pitch - Frequent urination</li> <li>- Faster rate of speech</li> </ul>
<b>Severe</b>	<ul style="list-style-type: none"> <li>- Perceptual field reduced to one detail or scattered details</li> <li>- Cannot complete tasks</li> <li>- Cannot solve problems or learn effectively</li> <li>- Behavior geared toward anxiety relief and is usually ineffective</li> <li>- Doesn't respond to redirection</li> <li>- Feels awe, dread, or horror Cries</li> <li>- Ritualistic behaviour</li> </ul>	<ul style="list-style-type: none"> <li>- Severe headache</li> <li>- Nausea, vomiting, and diarrhea</li> <li>- Trembling</li> <li>- Rigid stance</li> <li>- Vertigo - Pale</li> <li>- Tachycardia</li> <li>- Chest pain</li> </ul>
<b>Panic</b>	<ul style="list-style-type: none"> <li>- Perceptual field reduced to focus on self</li> <li>- Cannot process any environmental stimuli</li> <li>- Distorted perceptions</li> <li>- Loss of rational thought</li> <li>- Doesn't recognize potential danger</li> <li>- Can't communicate verbally</li> <li>- Possible delusions and hallucination - May be suicidal</li> </ul>	<ul style="list-style-type: none"> <li>- May bolt and run</li> <li>OR</li> <li>- Totally immobile and mute</li> <li>- Dilated pupils</li> <li>- Increased blood pressure and pulse</li> <li>- Flight, fight, or freeze</li> </ul>

## Treatment

Treatment for anxiety disorders usually involves medication and therapy. This combination produces better results than either one alone. Cognitive-behavioral therapy is used successfully to treat anxiety disorders.

- **Positive reframing** means turning negative messages into positive messages. The therapist teaches the person to create positive messages for use during panic episodes. For example, instead of thinking, "My heart is pounding. I think I'm going to die!" the client thinks, "I can stand this. This is just anxiety. It will go away." The client can write down these messages and keep them readily accessible such as in an address book, a calendar, or a wallet.

- **De-catastrophizing** involves the therapist's use of questions to more realistically appraise the situation. The therapist may ask, "What is the worst thing that could happen? Is that likely? Could you survive that? Is that as bad as you imagine?" The client uses thought-stopping and distraction techniques to jolt himself or herself from focusing on negative thoughts. Splashing the face with cold water, snapping a rubber band worn on the wrist, or shouting are all techniques that can break the cycle of negative thoughts.

- **Assertiveness training** helps the person take more control over life situations. Techniques help the person negotiate interpersonal situations and foster self-assurance. They involve using "I" statements to identify feelings and to communicate concerns or needs to others. Examples include "I feel angry when you turn your back while I'm talking," "I want to have 5 minutes of your time for an uninterrupted conversation about something important," and "I would like to have about 30 minutes in the evening to relax without interruption."

## Anxiolytics

Generic (trade) Name	Speed of Onset	Half- life (Hours)	Side Effects	Nursing Implications
Benzodiazepines				
Diazepam (Valium)	Fast	20-100	Dizziness, clumsiness, sedation, headache, fatigue, sexual dysfunction, blurred vision, dry throat and mouth, constipation, high potential for abuse and dependence	- Avoid other CNS depressants, such as antihistamines and alcohol. - Avoid caffeine. - Take care with potentially hazardous activities such as driving. - Rise slowly from lying or sitting position. - Use sugar-free beverages or hard candy. - Drink adequate fluids. - Take only as prescribed. - Do not stop taking the drug abruptly.
Alprazolam (Xanax)	Intermediate	6-12		
Chlordiazepoxide (Librium)	Intermediate	5-30		
Lorazepam (Ativan)	Intermediate	10-20		
Clonazepam (Klonopin)	Slow	18-50		
Oxazepam (Serax)	Slow	4-15		
Non-benzodiazepines				
Buspirone (BuSpar)	Very slow		Dizziness, restlessness, agitation, drowsiness, headache, weakness, nausea, vomiting, paradoxical excitement or euphoria	- Rise slowly from sitting position. Take care with potentially hazardous activities such as driving. - Take with food. - Report persistent restlessness, agitation, excitement, or euphoria to physician.
Meprobamate (Miltown, Equanil)	Rapid			

## ❖ Drugs used to treat Anxiety Disorders

Generic (Trade) Drug Name	Classification	Used to Treat
Alprazolam (Xanax)	Benzodiazepine	Anxiety, panic disorder, OCD, social phobia, agoraphobia
Buspirone (BuSpar)	Non-benzodiazepine anxiolytic	Anxiety, OCD, social phobia, GAD
Chlorazepate (Tranxene)	Benzodiazepine	Anxiety
Chlordiazepoxide (Librium)	Benzodiazepine	Anxiety
Clomipramine (Anafranil)	Tricyclic antidepressant	OCD
Clonazepam (Klonopin)	Benzodiazepine	Anxiety, panic disorder, OCD
Clonidine (Catapres)	Beta-blocker	Anxiety, panic disorder
Diazepam (Valium)	Benzodiazepine	Anxiety, panic disorder
Fluoxetine (Prozac)	SSRI antidepressant	Panic disorder, OCD, GAD
Fluvoxamine (Luvox)	SSRI antidepressant	OCD
Hydroxyzine (Vistaril, Atarax)	Antihistamine	Anxiety
Imipramine (Tofranil)	Tricyclic antidepressant	Anxiety, panic disorder, agoraphobia
Meprobamate (Miltown, Equanil)	Non-benzodiazepine anxiolytic	Anxiety
Oxazepam (Serax)	Benzodiazepine	Anxiety
Paroxetine (Paxil)	SSRI antidepressant	Social phobia, GAD
Propranolol (Inderal)	Alpha-adrenergic agonist	Anxiety, panic disorder, GAD
Sertraline (Zoloft)	SSRI antidepressant	Panic disorder, OCD, social phobia, GAD

### Elder Considerations

Anxiety that starts for the first time in late life is frequently associated with another condition such as depression, dementia, physical illness, or medication toxicity or withdrawal. Phobias, particularly agoraphobia, and GAD are the most common late-life anxiety disorders. Most people with late-onset agoraphobia attribute the start of the disorder to the sudden onset of a physical illness or as a response to a traumatic event such as a fall or assault.

### \* Community-Based Care

- Nurses encounter many people with anxiety disorders in community settings rather than in inpatient settings. Formal treatment for these clients usually occurs in community mental health clinics and in the offices of physicians, psychiatric clinical specialists, psychologists, or other mental health counselors. Because the person with an anxiety disorder often believes the irregular symptoms are related to medical problems, the family practitioner or advanced practice nurse can be the first health-care professional to evaluate him or her.
- Knowledge of community resources helps the nurse guide the client to appropriate referrals for assessment, diagnosis, and treatment. The nurse can refer the client to a psychiatrist or to an advanced practice psychiatric nurse for diagnosis, therapy, and medication. Other community resources such as anxiety disorder groups or self-help groups can provide support and help the client feel

### Mental Health Promotion

- Too often, anxiety is viewed negatively as something to avoid at all costs. Actually, for many people, anxiety is a warning they are not dealing with stress effectively. Learning to notice this warning and to make needed changes is a healthy way to deal with the stress of daily events.
- Stress and resulting anxiety are not associated exclusively with life problems. Events that are “positive” or desired, such as going away to college, getting a first job, getting married, and having children, are stressful and cause anxiety. Managing the effects of stress and anxiety in one’s life is important to being healthy. Tips for managing stress include the following:

- ✓ Keep a positive attitude and believe in yourself.
- ✓ Accept there are events you cannot control.
- ✓ Communicate assertively with others: talk about your feelings to others and express your feelings through laughing, crying, and so forth.
- ✓ Learn to relax.
- ✓ Exercise regularly.
- ✓ Eat well-balanced meals.
- ✓ Limit intake of caffeine and alcohol.
- ✓ Get enough rest and sleep.
- ✓ Set realistic goals and expectations and find an activity that is personally meaningful.
- ✓ Learn stress management techniques, such as relaxation, guided imagery, and meditation; practice them as part of your daily routine.

- For people with anxiety disorders, it is important to emphasize that the goal is effective management of stress and anxiety, not the total elimination of anxiety. Although medication is important to relieve excessive anxiety, it does not solve or eliminate the problem entirely. Learning anxiety management techniques and effective methods for coping with life and its stresses is essential for overall improvement in life quality.

#### \* **Panic Disorder**

- **Panic disorder** is composed of separate episodes of **panic attacks**, that is, 15 to 30 minutes of rapid, intense, escalating anxiety in which the person experiences great emotional fear as well as physiologic discomfort.
- During a panic attack, the person has overwhelmingly intense anxiety and displays four or more of the following symptoms: palpitations, sweating, tremors, shortness of breath, sense of suffocation, chest pain, nausea, abdominal distress, dizziness, paresthesia, chills, or hot flashes.
- Panic disorder is diagnosed when the person has recurrent, unexpected panic attacks followed by at least 1 month of persistent concern or worry about future attacks or their meaning or a significant behavioral change related to them.
- Slightly more than 75% of people with panic disorder have spontaneous initial attacks with no environmental trigger. Half of those with panic disorder have accompanying agoraphobia.
- Panic disorder is more common in people who have not graduated from college and are not married. The risk increases by 18% in people with depression.

#### \* **Generalized Anxiety Disorder**

- A person with GAD worries excessively and feels highly anxious at least 50% of the time for 6 months or more. Unable to control this focus on worry, the person has three or more of the following symptoms: uneasiness, irritability, muscle tension, fatigue, difficulty thinking, and sleep alterations.
- More people with this chronic disorder are seen by family physicians than by psychiatrists. The quality of life is diminished greatly in older adults with GAD. Buspirone (BuSpar) and SSRI antidepressants are the most effective treatments.

### **Nursing Care Plan/ *Anxious Behavior***

#### **Nursing Diagnosis**

Anxiety: Vague uneasy feeling of discomfort or dread accompanied by an autonomic response (the source often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an alerting signal that warns of approaching danger and enables the individual to take measures to deal with the threat.

Assessment Data	Expected Outcomes
<ul style="list-style-type: none"> <li>- Decreased attention span</li> <li>- Restlessness, irritability</li> <li>- Poor impulse control</li> <li>- Feelings of discomfort, apprehension, or helplessness</li> <li>- Hyperactivity, pacing</li> <li>- Wringing hands</li> <li>- Perceptual field deficits</li> <li>- Decreased ability to communicate verbally</li> </ul> <p><b>In addition, in panic anxiety</b></p> <ul style="list-style-type: none"> <li>- Inability to discriminate harmful stimuli or situations</li> <li>- Disorganized thought processes</li> <li>- Delusions</li> </ul>	<p><b>Immediate</b> <i>The client will</i></p> <ul style="list-style-type: none"> <li>- Be free from injury</li> <li>- Discuss feelings of dread, anxiety, and so forth</li> <li>- Respond to relaxation techniques with a decreased anxiety level</li> </ul> <p><b>Stabilization</b> <i>The client will</i></p> <ul style="list-style-type: none"> <li>- Demonstrate the ability to perform relaxation techniques</li> <li>- Reduce own anxiety level</li> </ul> <p><b>Community</b> <i>The client will</i></p> <ul style="list-style-type: none"> <li>- Be free from anxiety attacks</li> <li>- Manage the anxiety response to stress effectively</li> </ul>
Implementation	
Nursing Interventions	Rationale
- Remain with the client at all times when levels of anxiety are high (severe or panic).	- The client's safety is a priority. A highly anxious client should not be left alone-his or her anxiety will escalate.
- Move the client to a quiet area with minimal or decreased stimuli such as a small room or seclusion area.	- Anxious behavior can be escalated by external stimuli. In a large area, the client can feel lost and panicked, but a smaller room can enhance a sense of security.
- PRN ( <i>Pro re nata</i> ) medications may be indicated for high levels of anxiety, delusions, disorganized thoughts, and so forth	- Medication may be necessary to decrease anxiety to a level at which the client can feel safe.
- Remain calm in your approach to the client.	- The client will feel more secure if you are calm and if the client feels you are in control of the situation
- Use short, simple, and clear statements.	- The client's ability to deal with abstractions or complexity is impaired.
- Avoid asking or forcing the client to make choices.	- The client may not make sound decisions or may be unable to make decisions or solve problems.
- Be aware of your own feelings and level of discomfort.	- Anxiety is communicated interpersonally. - Being with an anxious client can raise your own anxiety level.
- Encourage the client's participation in relaxation exercises such as deep breathing, progressive muscle relaxation, meditation, and imagining being in a quiet, peaceful place.	- Relaxation exercises are effective, nonchemical ways to reduce anxiety.
- Teach the client to use relaxation techniques independently.	- Using relaxation techniques can give the client confidence in having control over anxiety.
- Help the client see that mild anxiety can be a positive promoter for change and does not need to be avoided.	- The client may feel that all anxiety is bad and not useful.

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