Key Terms

- agoraphobia
- anxiety
- anxiety disorders
- assertiveness training
- automatisms
- avoidance behavior
- compulsions
- decatastrophizing
- defense mechanisms
- depersonalization
- derealization
- exposure
- fear
- flooding
- mild anxiety
- moderate anxiety
- obsessions
- panic anxiety
- panic attack
- panic disorder
- phobia
- positive reframing
- primary gain
- response prevention
- secondary gain
- severe anxiety
- stress
- systematic desensitization

Learning Objectives

After reading this chapter, you should be able to

1. Describe anxiety as a response to stress.
2. Describe the levels of anxiety with behavioral changes related to each level.
3. Discuss the use of defense mechanisms by people with anxiety disorders.
4. Describe the current theories regarding the etiologies of major anxiety disorders.
5. Evaluate the effectiveness of treatment including medications for clients with anxiety disorders.
6. Apply the nursing process to the care of clients with anxiety and anxiety disorders.
7. Provide teaching to clients, families, caregivers, and communities to increase understanding of anxiety and stress-related disorders.
8. Examine your feelings, beliefs, and attitudes regarding clients with anxiety disorders.
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 dissipates when the situation has been resolved.

Anxiety disorders comprise a group of conditions that share a key feature of excessive anxiety with ensuing behavioral, emotional, cognitive, and physiologic responses. Clients suffering from anxiety disorders can demonstrate unusual behaviors such as panic without reason, unwarranted 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.

This chapter discusses anxiety as an expected response to stress. It also explores anxiety disorders, with particular emphasis on panic disorder and obsessive-compulsive disorder (OCD).

ANXIETY AS A RESPONSE TO STRESS

Stress is the wear and tear that life causes on the body (Selye, 1956). 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.

Hans Selye (1956, 1974), an endocrinologist, identified the physiologic aspects of stress, which he labeled the general adaptation syndrome. He used laboratory animals to assess biologic system changes; the stages of the body’s physical responses to pain, heat, toxins, and restraint; and, later, the mind’s emotional responses to real or perceived stressors. He determined 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 norepinephrine for fuel) and organs (such as the liver, 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 abate.
- The exhaustion stage occurs when the person has responded negatively to anxiety and stress: body stores are depleted 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 adrenaline (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 yells “fire,” others around
them can become anxious as they picture a fire and the pos-
tible threat that represents. Viewing a distraught mother
searching for her lost child in a shopping mall can cause
anxiety in others as they imagine the panic she is experi-
encing. They can convey anxiety nonverbally through
empathy, which is the sense of walking in another person’s
shoes for a moment in time (Sullivan, 1952). 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 per-
son feels the tension in a room where two people have been
arguing and are now not speaking to each other.

Levels of Anxiety

Anxiety has both healthy and harmful aspects depending on
its degree and duration as well as on how well the person
copes with it. Anxiety has four levels: mild, moderate,
severe, and panic (Table 13.1). Each level causes both phys-
iologic and emotional changes in the person.

Mild anxiety is a sensation that something is different and
warrants special attention. Sensory stimulation increases and
helps the person focus attention to learn, solve problems,
think, act, feel, and protect himself or herself. Mild anxiety
often motivates people to make changes or to engage in goal-
directed activity. For example, it helps students to focus on
studying for an examination.

Moderate anxiety is the disturbing feeling that some-
thing is definitely wrong; the person becomes nervous or
agitated. In moderate anxiety, the person can still process
information, solve problems, and learn new things with
assistance from others. He or she has difficulty concentrat-
ing independently but can be redirected to the topic. For
example, the nurse might be giving preoperative instruc-
tions to a client who is anxious about the upcoming surgi-
cal procedure. As the nurse is teaching, the client’s attention
wanders but the nurse can regain the client’s attention and
direct him or her back to the task at hand.

As the person progresses to severe anxiety and panic,
more primitive survival skills take over, defensive responses
ensue, and cognitive skills decrease significantly. A per-
son with severe anxiety has trouble thinking and reason-
ing. Muscles tighten and vital signs increase. The person
paces; is restless, irritable, and angry; or uses other sim-
ilar emotional-psychomotor means to release tension. In
panic, the emotional-psychomotor realm predominates with
accompanying fight, flight, or freeze responses. Adrenaline
surge greatly increases vital signs. Pupils enlarge to let in
more light, and the only cognitive process focuses on the
person’s defense.

Working With Anxious Clients

Nurses encounter anxious clients and families in a wide
variety of situations such as before surgery and in emer-
gency 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 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 diffi-
culty 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 tangent.

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 nonstimulating 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 sustained indefinitely but can last from 5 to 30 minutes.

### Table 13.1 LEVELS OF ANXIETY

<table>
<thead>
<tr>
<th>Anxiety Level</th>
<th>Psychological Responses</th>
<th>Physiologic Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild</strong></td>
<td>Wide perceptual field</td>
<td>Restlessness</td>
</tr>
<tr>
<td></td>
<td>Sharpened senses</td>
<td>Fidgeting</td>
</tr>
<tr>
<td></td>
<td>Increased motivation</td>
<td>GI “butterflies”</td>
</tr>
<tr>
<td></td>
<td>Effective problem solving</td>
<td>Difficulty sleeping</td>
</tr>
<tr>
<td></td>
<td>Increased learning ability</td>
<td>Hypersensitivity to noise</td>
</tr>
<tr>
<td></td>
<td>Irritability</td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Perceptual field narrowed to immediate task</td>
<td>Muscle tension</td>
</tr>
<tr>
<td></td>
<td>Selectively attentive</td>
<td>Pounding pulse</td>
</tr>
<tr>
<td></td>
<td>Cannot connect thoughts or events independently</td>
<td>Headache</td>
</tr>
<tr>
<td></td>
<td>Increased use of automatisms</td>
<td>Dry mouth</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Perceptual field reduced to one detail or scattered details</td>
<td>Nausea, vomiting, and diarrhea</td>
</tr>
<tr>
<td></td>
<td>Cannot complete tasks</td>
<td>Trembling</td>
</tr>
<tr>
<td></td>
<td>Cannot solve problems or learn effectively</td>
<td>Rigid stance</td>
</tr>
<tr>
<td></td>
<td>Behavior geared toward anxiety relief and is usually ineffective</td>
<td>Vertigo</td>
</tr>
<tr>
<td></td>
<td>Doesn’t respond to redirection</td>
<td>Pale</td>
</tr>
<tr>
<td></td>
<td>Feels awe, dread, or horror</td>
<td>Tachycardia</td>
</tr>
<tr>
<td></td>
<td>Cries</td>
<td>Chest pain</td>
</tr>
<tr>
<td></td>
<td>Ritualistic behavior</td>
<td></td>
</tr>
<tr>
<td><strong>Panic</strong></td>
<td>Perceptual field reduced to focus on self</td>
<td>May bolt and run</td>
</tr>
<tr>
<td></td>
<td>Cannot process any environmental stimuli</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Distorted perceptions</td>
<td>Totally immobile and mute</td>
</tr>
<tr>
<td></td>
<td>Loss of rational thought</td>
<td>Dilated pupils</td>
</tr>
<tr>
<td></td>
<td>Doesn’t recognize potential danger</td>
<td>Increased blood pressure and pulse</td>
</tr>
<tr>
<td></td>
<td>Can’t communicate verbally</td>
<td>Flight, fight, or freeze</td>
</tr>
<tr>
<td></td>
<td>Possible delusions and hallucination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May be suicidal</td>
<td></td>
</tr>
</tbody>
</table>
When working with an anxious person, the nurse must be aware of his or her own anxiety level. It is easy for the nurse to become increasingly anxious. Remaining calm and in control is essential if the nurse is going to work effectively with the client.

Short-term anxiety can be treated with anxiolytic medications (Table 13.2). Most of these drugs are benzodiazepines, which are commonly prescribed for anxiety. Benzodiazepines have a high potential for abuse and dependence, however, so their use should be short-term, ideally no longer than 4 to 6 weeks. These drugs are designed to relieve anxiety so that the person can deal more effectively with whatever crisis or situation is causing stress. Unfortunately, many people see these drugs as a “cure” for anxiety and continue to use them instead of learning more effective coping skills or making needed changes. Chapter 2 contains additional information about anxiolytic drugs.

**Overview of Anxiety Disorders**

Anxiety disorders are diagnosed when anxiety no longer functions as a signal of danger or a motivation for needed change but becomes chronic and permeates major portions of the person’s life, resulting in maladaptive behaviors and emotional disability. Anxiety disorders have many manifestations, but anxiety is the key feature of each (American Psychiatric Association [APA], 2000). Types of anxiety disorders include the following:

- Agoraphobia with or without panic disorder
- Panic disorder
- Specific phobia
- Social phobia
- OCD
- Generalized anxiety disorder (GAD)
- Acute stress disorder
- Posttraumatic stress disorder

Panic disorder and OCD are the most common and are the focus of this chapter. Posttraumatic stress disorder is addressed in Chapter 11.

**INCIDENCE**

Anxiety disorders have the highest prevalence rates of all mental disorders in the United States. Nearly one in four adults in the United States is affected, and the magnitude of anxiety disorders in young people is similar (Merikangas, 2005). Anxiety disorders are more prevalent in women, people younger than age 45 years, people who are divorced or separated, and people of lower socioeconomic status. The exception is OCD, which is equally prevalent in men and women but is more common among boys than girls.

**ONSET AND CLINICAL COURSE**

The onset and clinical course of anxiety disorders are extremely variable depending on the specific disorder. These aspects are discussed later in this chapter within the context of each disorder.

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**Table 13.2 ANXIOLYTIC DRUGS**

<table>
<thead>
<tr>
<th>Generic (Trade) Name</th>
<th>Speed of Onset</th>
<th>Side Effects</th>
<th>Nursing Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>Very fast</td>
<td>Dizziness, clumsiness, sedation, headache, fatigue, sexual dysfunction, blurred vision, dry throat and mouth, constipation, high potential for abuse and dependence</td>
<td>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.</td>
</tr>
<tr>
<td>Chlorazepate (Tranxene)</td>
<td>Fast</td>
<td>Dizziness, restlessness, agitation, drowsiness, headache, weakness, nausea, vomiting, paradoxical excitement or euphoria</td>
<td></td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>Moderately slow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxazepam (Serax)</td>
<td>Moderately slow</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nonbenzodiazepines</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buspirone (BuSpar)</td>
<td>Very slow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meprobamate (Miltown, Equanil)</td>
<td>Rapid</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Disorder

Agoraphobia is anxiety about or avoidance of places or situations from which escape might be difficult or help might be unavailable.

Panic disorder is characterized by recurrent, unexpected panic attacks that cause constant concern. Panic attack is the sudden onset of intense apprehension, fearfulness, or terror associated with feelings of impending doom.

Specific phobia is characterized by significant anxiety provoked by a specific feared object or situation, which often leads to avoidance behavior.

Social phobia is characterized by anxiety provoked by certain types of social or performance situations, which often leads to avoidance behavior.

Obsessive-compulsive disorder involves obsessions (thoughts, impulses, or images) that cause marked anxiety and/or compulsions (repetitive behaviors or mental acts) that attempt to neutralize anxiety.

Generalized anxiety disorder is characterized by at least 6 months of persistent and excessive worry and anxiety.

Acute stress disorder is the development of anxiety, dissociation, and other symptoms within 1 month of exposure to an extremely traumatic stressor; it lasts 2 days to 4 weeks.

Posttraumatic stress disorder is characterized by the re-experiencing of an extremely traumatic event, avoidance of stimuli associated with the event, numbing of responsiveness, and persistent increased arousal; it begins within 3 months to years after the event and may last a few months or years.

Symptoms

Avoids being outside alone or at home alone; avoids traveling in vehicles; impaired ability to work; difficulty meeting daily responsibilities (e.g., grocery shopping, going to appointments); knows response is extreme

A discrete episode of panic lasting 15 to 30 minutes with four or more of the following: palpitations, sweating, trembling or shaking, shortness of breath, choking or smothering sensation, chest pain or discomfort, nausea, derealization or depersonalization, fear of dying or going crazy, paresthesias, chills or hot flashes

Marked anxiety response to the object or situation; avoidance or suffered endurance of object or situation; significant distress or impairment of daily routine, occupation, or social functioning; adolescents and adults recognize their fear as excessive or unreasonable.

Fear of embarrassment or inability to perform; avoidance or dreaded endurance of behavior or situation; recognition that response is irrational or excessive; belief that others are judging him or her negatively; significant distress or impairment in relationships, work, or social life; anxiety can be severe or panic level.

Recurrent, persistent, unwanted, intrusive thoughts, impulses, or images beyond worrying about realistic life problems; attempts to ignore, suppress, or neutralize obsessions with compulsions that are mostly ineffective; adults and adolescents recognize that obsessions and compulsions are excessive and unreasonable.

Apprehensive expectations more days than not for 6 months or more about several events or activities; uncontrollable worrying; significant distress or impaired social or occupational functioning; three of the following symptoms: restlessness, easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, sleep disturbance

Exposure to traumatic event causing intense fear, helplessness, or horror; marked anxiety symptoms or increased arousal; significant distress or impaired functioning; persistent re-experiencing of the event; three of the following symptoms: sense of emotional numbing or detachment, feeling dazed, derealization, depersonalization, dissociative amnesia (inability to recall important aspect of the event)

Exposure to traumatic event involving intense fear, helplessness or horror; re-experiencing (intrusive recollections or dreams, flashbacks, physical and psychological distress over reminders of the event); avoidance of memory-provoking stimuli and numbing of general responsiveness (avoidance of thoughts, feelings, conversations, people, places, amnesia, diminished interest or participation in life events, feeling detached or estranged from others, restricted affect, sense of foreboding); increased arousal (sleep disturbance, irritability or angry outbursts, difficulty concentrating, hypervigilance, exaggerated startle response); significant distress or impairment

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 impending danger and enables the individual to take measures to deal with the threat.

**ASSESSMENT DATA**

- Decreased attention span
- Restlessness, irritability
- Poor impulse control
- Feelings of discomfort, apprehension, or helplessness
- Hyperactivity, pacing
- Wringing hands
- Perceptual field deficits
- Decreased ability to communicate verbally
  
  *In addition, in panic anxiety*
  
  - Inability to discriminate harmful stimuli or situations
  - Disorganized thought processes
  - Delusions

**EXPECTED OUTCOMES**

**Immediate**

*The client will*

- Be free from injury
- Discuss feelings of dread, anxiety, and so forth
- Respond to relaxation techniques with a decreased anxiety level

**Stabilization**

*The client will*

- Demonstrate the ability to perform relaxation techniques
- Reduce own anxiety level

**Community**

*The client will*

- Be free from anxiety attacks
- Manage the anxiety response to stress effectively

**IMPLEMENTATION**

**Nursing Interventions** *denotes collaborative interventions*

Remain with the client at all times when levels of anxiety are high (severe or panic).

Move the client to a quiet area with minimal or decreased stimuli such as a small room or seclusion area.

Remain calm in your approach to the client.

Use short, simple, and clear statements.

Avoid asking or forcing the client to make choices.

PRN medications may be indicated for high levels of anxiety, delusions, disorganized thoughts, and so forth.

Be aware of your own feelings and level of discomfort.

Rationale

The client’s safety is a priority. A highly anxious client should not be left alone—his or her anxiety will escalate.

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.

The client will feel more secure if you are calm and if the client feels you are in control of the situation. The client’s ability to deal with abstractions or complexity is impaired.

The client may not make sound decisions or may be unable to make decisions or solve problems.

Medication may be necessary to decrease anxiety to a level at which the client can feel safe.

Anxiety is communicated interpersonally. Being with an anxious client can raise your own anxiety level.
**Nursing Care Plan: Anxious Behavior, cont.**

**IMPLEMENTATION**

**Nursing Interventions** *denotes collaborative interventions*

Encourage the client’s participation in relaxation exercises such as deep breathing, progressive muscle relaxation, meditation, and imagining being in a quiet, peaceful place.

Teach the client to use relaxation techniques independently.

Help the client see that mild anxiety can be a positive catalyst for change and does not need to be avoided.

**Rationale**

Relaxation exercises are effective, nonchemical ways to reduce anxiety.

Using relaxation techniques can give the client confidence in having control over anxiety.

The client may feel that all anxiety is bad and not useful.


**RELATED DISORDERS**

Anxiety disorder due to a general medical condition is diagnosed when the prominent symptoms of anxiety are judged to result directly from a physiologic condition. The person may have panic attacks, generalized anxiety, or obsessions or compulsions. Medical conditions causing this disorder can include endocrine dysfunction, chronic obstructive pulmonary disease, congestive heart failure, and neurologic conditions.

Substance-induced anxiety disorder is anxiety directly caused by drug abuse, a medication, or exposure to a toxin. Symptoms include prominent anxiety, panic attacks, phobias, obsessions, or compulsions.

Separation anxiety disorder is excessive anxiety concerning separation from home or from persons, parents, or caregivers to whom the client is attached. It occurs when it is no longer developmentally appropriate and before 18 years of age.

Adjustment disorder is an emotional response to a stressful event, such as one involving financial issues, medical illness, or a relationship problem, that results in clinically significant symptoms such as marked distress or impaired functioning.

**ETIOLOGY**

**Biologic Theories**

**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 heritabilities are greater than 0.6 and indicate that genetic influences dominate.
- Moderate heritabilities are 0.3 to 0.5 and suggest an even greater influence of genetic and nongenetic factors.
- Heritabilities less than 0.3 mean that genetics are negligible 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 (McMahon & Kassem, 2005). At this point, current research indicates a clear genetic susceptibility to or vulnerability for anxiety disorders; however, additional factors are necessary for these disorders to actually develop.

**NEUROCHEMICAL THEORIES**

Gamma-aminobutyric acid (γ-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. It is available in one third of the nerve synapses, especially those in the limbic system and in the locus ceruleus, the area where the neurotransmitter norepinephrine, which excites cellular function, is produced. 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 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 (Neumeister et al., 2005).
Psychodynamic Theories

INTRAPSYCHIC/PSYCHOANALYTIC THEORIES

Freud (1936) saw a person’s innate anxiety as the stimulus for behavior. He described defense mechanisms as the human’s attempt to control awareness of and to reduce anxiety (see Chapter 3). 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.

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 nurturing, 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 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.

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 the causes for them. They contend that disturbing behaviors that develop and interfere with a person’s life can be extinguished or unlearned by repeated experiences guided by a trained therapist.

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. One intense anxiety reaction is koro, or a man’s profound fear that his penis will retract into the abdomen and he will then die. Accepted forms of treatment include having the person firmly hold his penis until the fear passes, often with assistance from family members or friends, and clamping the penis to a wooden box. In women, koro is the fear that the vulva and nipples will disappear (Spector, 2004).

Susto is diagnosed in some Hispanics (Peruvians, Bolivians, Colombians, and Central and South American Indians) 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.

TREATMENT

Treatment for anxiety disorders usually involves medication and therapy. This combination produces better results than either one alone (Charney, 2005). Drugs used to treat anxiety disorders are listed in Table 13.3. Antidepressants are discussed in detail in Chapter 15. 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, calendar, or wallet.

Decatastrophizing 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 him 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.”
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 abrupt onset of a physical illness or as a response to a traumatic event such as a fall or mugging. Late-onset GAD is usually associated with depression. Though less common, panic attacks can occur in later life and are often related to depression or a physical illness such as cardiovascular, gastrointestinal, or chronic pulmonary diseases. Ruminative thoughts are common in late-life depression and can take the form of obsessions such as contamination fears, pathologic doubt, or fear of harming others. The treatment of choice for anxiety disorders in the elderly is selective serotonin reuptake inhibitor (SSRI) antidepressants. Initial treatment involves doses lower than the usual starting doses for adults to ensure the elderly client can tolerate the medication: if started on too high a dose, SSRIs can exacerbate anxiety symptoms in elderly clients (Flint, 2004).

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 sporadic 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 less isolated and lonely.

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 heed 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.

Table 13.3

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

GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; SSRI, selective serotonin reuptake inhibitor.
• Talk about your feelings to others.
• 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.
• 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 discrete 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, paresthesias, 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 (Merikangas, 2005).

**Clinical Course**

The onset of panic disorder peaks in late adolescence and the mid-30s. Although panic anxiety might be normal in someone experiencing a life-threatening situation, a person with panic disorder experiences these emotional and physiologic responses without this stimulus. The memory of the panic attack coupled with the fear of having more can lead to avoidance behavior. In some cases, the person becomes housebound or stays in a limited area near home such as on the block or within town limits. This behavior is known as agoraphobia (“fear of the marketplace” or fear of being outside). Some people with agoraphobia fear stepping outside the front door because a panic attack may occur as soon as they leave the house. Others can leave the house but feel safe from the anticipatory fear of having a panic attack only within a limited area. Agoraphobia also can occur alone without panic attacks.

The behavior patterns of people with agoraphobia clearly demonstrate the concepts of primary and secondary gain associated with many anxiety disorders. Primary gain is the relief of anxiety achieved by performing the specific anxiety-driven behavior such as staying in the house to avoid the anxiety of leaving a safe place. Secondary gain is the attention received from others as a result of these behaviors. For instance, the person with agoraphobia may receive attention and caring concern from family members, who also assume all the responsibilities of family life outside the home (e.g., work, shopping). Essentially, these compassionate significant others become enablers of the self-imprisonment of the person with agoraphobia.

**Treatment**

Panic disorder is treated with cognitive-behavioral techniques, deep breathing and relaxation, and medications such as benzodiazepines, SSRI antidepressants, tricyclic antidepressants, and antihypertensives such as clonidine (Catapres) and propranolol (Inderal).
APPLICATION OF THE NURSING PROCESS: PANIC DISORDER

Assessment

Box 13.1 presents the Hamilton Rating Scale for Anxiety. The nurse can use this tool along with the following detailed discussion to guide his or her assessment of the client with panic disorder.

HISTORY

The client usually seeks treatment for panic disorder after he or she has experienced several panic attacks. The client

Box 13.1 HAMILTON RATING SCALE FOR ANXIETY

Instructions: This checklist is to assist the physician or psychiatrist in evaluating each patient as to his or her degree of anxiety and pathological condition. Please fill in the appropriate rating:

NONE = 0  MILD = 1  MODERATE = 2  SEVERE = 3  SEVERE, GROSSLY DISABLING = 4

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
<th>Item</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety mood</td>
<td>Worries, anticipation of the worst, fearful anticipation, irritability</td>
<td>Cardiovascular symptoms</td>
<td>Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat</td>
</tr>
<tr>
<td>Tension</td>
<td>Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax</td>
<td>Respiratory symptoms</td>
<td>Pressure or constriction in chest, choking feelings, sighing, dyspnea</td>
</tr>
<tr>
<td>Fears</td>
<td>Of dark, of strangers, of being left alone, of animals, of traffic, of crowds</td>
<td>Gastrointestinal symptoms</td>
<td>Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors</td>
<td>Genitourinary symptoms</td>
<td>Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence</td>
</tr>
<tr>
<td>Intellectual (cognitive)</td>
<td>Difficulty in concentration, poor memory</td>
<td>Autonomic symptoms</td>
<td>Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair</td>
</tr>
<tr>
<td>Depressed mood</td>
<td>Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic (muscular)</td>
<td>Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic (sensory)</td>
<td>Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, picking sensation</td>
<td>Behavior at interview</td>
<td>Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos</td>
</tr>
</tbody>
</table>

Additional Comments:

Investigator's Signature:

that he or she is dying, losing control, or “going insane.” During a panic attack, the client is overwhelmed, believing things are not real (derealization) or sensing that things are not real (depersonalization).

**MOOD AND AFFECT**
Assessment of mood and affect may reveal that the client is anxious, worried, tense, depressed, serious, or sad. When discussing the panic attacks, the client may be tearful. He or she may express anger at himself or herself for being “unable to control myself.” Most clients are distressed about the intrusion of anxiety attacks in their lives. They may find themselves consumed with worry about when the next panic attack will occur or how to deal with it.

**THOUGHT PROCESSES AND CONTENT**
During a panic attack, the client is overwhelmed, believing that he or she is dying, losing control, or “going insane.”

**GENERAL APPEARANCE AND MOTOR BEHAVIOR**
The nurse assesses the client’s general appearance and motor behavior. The client may appear entirely “normal” or may have signs of anxiety if he or she is apprehensive about having a panic attack in the next few moments. If the client is anxious, speech may increase in rate, pitch, and volume, and he or she may have difficulty sitting in a chair. Automatisms, which are automatic, unconscious mannerisms, may be apparent. Examples include tapping fingers, jingling keys, or twisting hair. Automatisms are geared toward anxiety relief and increase in frequency and intensity with the client’s anxiety level.

**MOOD AND AFFECT**
Assessment of mood and affect may reveal that the client is anxious, worried, tense, depressed, serious, or sad. When discussing the panic attacks, the client may be tearful. He or she may express anger at himself or herself for being “unable to control myself.” Most clients are distressed about the intrusion of anxiety attacks in their lives. During a panic attack, the client may describe feelings of being disconnected from himself or herself (depersonalization) or sensing that things are not real (derealization).

**SENSORIUM AND INTELLECTUAL PROCESSES**
During a panic attack, the client may become confused and disoriented. He or she cannot take in environmental cues and respond appropriately. These functions are restored to normal after the panic attack subsides.

**JUDGMENT AND INSIGHT**
Judgment is suspended during panic attacks; in an effort to escape, the person can run out of a building and into the street in front of a speeding car before the ability to assess safety has returned. Insight into panic disorder occurs only after the client has been educated about the disorder. Even then, clients initially believe they are helpless and have no control over their anxiety attacks.

**SELF-CONCEPT**
It is important for the nurse to assess self-concept in clients with panic disorder. These clients often make self-blaming statements such as “I can’t believe I’m so weak and out of control” or “I used to be a happy, well-adjusted person.” They may evaluate themselves negatively in all aspects of their lives. They may find themselves consumed with worry about impending attacks and unable to do many things they did before having panic attacks.
ROLES AND RELATIONSHIPS

Because of the intense anticipation of having another panic attack, the person may report alterations in his or her social, occupational, or family life. The person typically avoids people, places, and events associated with previous panic attacks. For example, the person may no longer ride the bus if he or she has had a panic attack on a bus. Although avoiding these objects does not stop the panic attacks, the person’s sense of helplessness is so great that he or she may take even more restrictive measures to avoid them, such as quitting work and remaining at home.

PHYSIOLOGIC AND SELF-CARE CONCERNS

The client often reports problems with sleeping and eating. The anxiety of apprehension between panic attacks may interfere with adequate, restful sleep even though the person may spend hours in bed. Clients may experience loss of appetite or eat constantly in an attempt to ease the anxiety.

Data Analysis

The following nursing diagnoses may apply to the client with panic disorder:

- Risk for Injury
- Anxiety
- Situational Low Self-Esteem (panic attacks)
- Ineffective Coping
- Powerlessness
- Ineffective Role Performance
- Disturbed Sleep Pattern

Outcome Identification

Outcomes for clients with panic disorders include the following:

- The client will be free from injury.
- The client will verbalize feelings.
- The client will demonstrate use of effective coping mechanisms.
- The client will demonstrate effective use of methods to manage anxiety response.
- The client will verbalize a sense of personal control.
- The client will reestablish adequate nutritional intake.
- The client will sleep at least 6 hours per night.

Intervention

PROMOTING SAFETY AND COMFORT

During a panic attack, the nurse’s first concern is to provide a safe environment and to ensure the client’s privacy. If the environment is overstimulating, the client should move to a less stimulating place. A quiet place reduces anxiety and provides privacy for the client.

NURSING INTERVENTIONS FOR PANIC DISORDER

- Provide a safe environment and ensure client’s privacy during a panic attack.
- Remain with the client during a panic attack.
- Help client to focus on deep breathing.
- Talk to client in a calm, reassuring voice.
- Teach client to use relaxation techniques.
- Help client to use cognitive restructuring techniques.
- Engage client to explore how to decrease stressors and anxiety-provoking situations.

The nurse remains with the client to help calm him or her down and to assess client behaviors and concerns. After getting the client’s attention, the nurse uses a soothing, calm voice and gives brief directions to assure the client that he or she is safe:

“John, look around. It’s safe, and I’m here with you. Nothing is going to happen. Take a deep breath.”

Reassurances and a calm demeanor can help to reduce anxiety. When the client feels out of control, the nurse can let the client know that the nurse is in control until the client regains self-control.

USING THERAPEUTIC COMMUNICATION

Clients with anxiety disorders can collaborate with the nurse in the assessment and planning of their care; thus, rapport between nurse and client is important. Communication should be simple and calm because the client with severe anxiety cannot pay attention to lengthy messages and may pace to release energy. The nurse can walk with the client who feels unable to sit and talk. The nurse should evaluate carefully the use of touch because clients with high anxiety may interpret touch by a stranger as a threat and pull away abruptly.

As the client’s anxiety diminishes, cognition begins to return. When anxiety has subsided to a manageable level, the nurse uses open-ended communication techniques to discuss the experience:

Nurse: “It seems your anxiety is subsiding. Is that correct?” or “Can you share with me what it was like a few minutes ago?”

At this point, the client can discuss his or her emotional responses to physiologic processes and behaviors and can try to regain a sense of control.
MANAGING ANXIETY

The nurse can teach the client relaxation techniques to use when he or she is experiencing stress or anxiety. Deep breathing is simple; anyone can do it. Guided imagery and progressive relaxation are methods to relax taut muscles: Guided imagery involves imagining a safe, enjoyable place to relax. In progressive relaxation, the person progressively tightens, holds, and then relaxes muscle groups while letting tension flow from the body through rhythmic breathing. Cognitive restructuring techniques (discussed earlier) also may help the client to manage his or her anxiety response.

For any of these techniques, it is important for the client to learn and to practice them when he or she is relatively calm. When adept at these techniques, the client is more likely to use them successfully during panic attacks or periods of increased anxiety. Clients are likely to believe that self-control is returning when using these techniques helps them to manage anxiety. When clients believe they can manage the panic attack, they spend less time worrying about and anticipating the next one, which reduces their overall anxiety level.

PROVIDING CLIENT AND FAMILY EDUCATION

Client and family education is of primary importance when working with clients who have anxiety disorders. The client learns ways to manage stress and to cope with reactions to stress and stress-provoking situations. With education about the efficacy of combined psychotherapy and medication and the effects of the prescribed medication, the client can become the chief treatment manager of the anxiety disorder. It is important for the nurse to educate the client and family members about the physiology of anxiety and the merits of using combined psychotherapy and drug management. Such a combined treatment approach along with stress-reduction techniques can help the client to manage these drastic reactions and allow him or her to gain a sense of self-control. The nurse should help the client to understand that these therapies and drugs do not “cure” the disorder but are methods to help him or her to control and manage it. Client and family education regarding medications should include the recommended dosage and dosage regimen, expected effects, side effects and how to handle them, and substances that have a synergistic or antagonistic effect with the drug.

The nurse encourages the client to exercise regularly. Routine exercise helps to metabolize adrenaline, reduces panic reactions, and increases production of endorphins; all these activities increase feelings of well-being.

Evaluation

Evaluation of the plan of care must be individualized. Ongoing assessment provides data to determine whether the client’s outcomes were achieved. The client’s perception of the success of treatment also plays a part in evaluation. Even if all outcomes are achieved, the nurse must ask if the client is comfortable or satisfied with the quality of life.

Evaluation of the treatment of panic disorder is based on the following:

- Does the client understand the prescribed medication regimen, and is he or she committed to adhering to it?
- Have the client’s episodes of anxiety decreased in frequency or intensity?
- Does the client understand various coping methods and when to use them?
- Does the client believe that his or her quality of life is satisfactory?

PHOBIAS

A phobia is an illogical, intense, persistent fear of a specific object or a social situation that causes extreme distress and interferes with normal functioning. Phobias usually do not result from past negative experiences. In fact, the person may never have had contact with the object of the phobia. People with phobias understand that their fear is unusual and irrational and may even joke about how “silly” it is. Nevertheless, they feel powerless to stop it (Andreasen et al., 2006).

People with phobias develop anticipatory anxiety even when thinking about possibly encountering the dreaded phobic object or situation. They engage in avoidance behavior that often severely limits their lives. Such avoidance behavior usually does not relieve the anticipatory anxiety for long.

There are three categories of phobias:
- Agoraphobia (discussed earlier)
- Specific phobia, which is an irrational fear of an object or situation
- Social phobia, which is anxiety provoked by certain social or performance situations

CLIENT/FAMILY EDUCATION FOR PANIC DISORDER

- Review breathing control and relaxation techniques.
- Discuss positive coping strategies.
- Encourage regular exercise.
- Emphasize the importance of maintaining prescribed medication regimen and regular follow-up.
- Describe time management techniques such as creating “to do” lists with realistic estimated deadlines for each activity, crossing off completed items for a sense of accomplishment, and saying “no.”
- Stress the importance of maintaining contact with community and participating in supportive organizations.
Many people express “phobias” about snakes, spiders, rats, or similar objects. These fears are very specific, easy to avoid, and cause no anxiety or worry. The diagnosis of a phobic disorder is made only when the phobic behavior significantly interferes with the person’s life by creating marked distress or difficulty in interpersonal or occupational functioning.

Specific phobias are subdivided into the following categories:
- Natural environmental phobias: fear of storms, water, heights, or other natural phenomena
- Blood-injection phobias: fear of seeing one’s own or others’ blood, traumatic injury, or an invasive medical procedure such as an injection
- Situational phobias: fear of being in a specific situation such as on a bridge or in a tunnel, elevator, small room, hospital, or airplane
- Animal phobia: fear of animals or insects (usually a specific type). Often this fear develops in childhood and can continue through adulthood in both men and women. Cats and dogs are the most common phobic objects.
- Other types of specific phobias: for example, fear of getting lost while driving if not able to make all right (and no left) turns to get to one’s destination

In **social phobia**, also known as **social anxiety disorder**, the person becomes severely anxious to the point of panic or incapacitation when confronting situations involving people. Examples include making a speech, attending a social engagement alone, interacting with the opposite sex or with strangers, and making complaints. The fear is rooted in low self-esteem and concern about others’ judgments. The person fears looking socially inept, appearing anxious, or doing something embarrassing such as burping or spilling food. Other social phobias include fear of eating in public, using public bathrooms, writing in public, or becoming the center of attention. A person may have one or several social phobias; the latter is known as generalized social phobia (Culpepper, 2006).

**Onset and Clinical Course**

Specific phobias usually occur in childhood or adolescence. In some cases, merely thinking about or handling a plastic model of the dreaded object can create fear. Specific phobias that persist into adulthood are lifelong 80% of the time.

The peak age of onset for social phobia is middle adolescence; it sometimes emerges in a person who was shy as a child. The course of social phobia is often continuous, although the disorder may become less severe during adulthood. Severity of impairment fluctuates with life stress and demands.

**Treatment**

Behavioral therapy works well. Behavioral therapists initially focus on teaching what anxiety is, helping the client to identify anxiety responses, teaching relaxation techniques, setting goals, discussing methods to achieve those goals, and helping the client to visualize phobic situations. Therapies that help the client to develop self-esteem and self-control are common and include positive reframing and assertiveness training (explained earlier).

One behavioral therapy often used to treat phobias is **systematic (serial) desensitization**, in which the therapist progressively exposes the client to the threatening object in a safe setting until the client’s anxiety decreases. During each exposure, the complexity and intensity of exposure gradually increase, but the client’s anxiety decreases. The reduced anxiety serves as a positive reinforcement until the anxiety is ultimately eliminated. For example, for the client who fears flying, the therapist would encourage the client to hold a small model airplane while talking about his or her experiences; later, the client would hold a larger model airplane and talk about flying. Even later exposures might include walking past an airport, sitting in a parked airplane, and, finally, taking a short ride in a plane. Each session’s challenge is based on the success achieved in previous sessions (Andreasen & Black, 2006).

**Flooding** is a form of rapid desensitization in which a behavioral therapist confronts the client with the phobic object (either a picture or the actual object) until it no longer produces anxiety. Because the client’s worst fear has been realized and the client did not die, there is little rea-
son to fear the situation anymore. The goal is to rid the client of the phobia in one or two sessions. This method is highly anxiety producing and should be conducted only by a trained psychotherapist under controlled circumstances and with the client’s consent.

Drugs used to treat phobias are listed in Table 13.3.

**OBSESSIVE-COMPULSIVE DISORDER**

Obsessions are recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses that cause marked anxiety and interfere with interpersonal, social, or occupational function. The person knows these thoughts are excessive or unreasonable but believes he or she has no control over them. Compulsions are ritualistic or repetitive behaviors or mental acts that a person carries out continuously in an attempt to neutralize anxiety. Usually, the theme of the ritual is associated with that of the obsession, such as repetitive hand-washing when someone is obsessed with contamination or repeated prayers or confession for someone obsessed with blasphemous thoughts. Common compulsions include the following:

- Checking rituals (repeatedly making sure the door is locked or the coffee pot is turned off)
- Counting rituals (each step taken, ceiling tiles, concrete blocks, desks in a classroom)
- Washing and scrubbing until the skin is raw
- Praying or chanting
- Touching, rubbing, or tapping (feeling the texture of each material in a clothing store; touching people, doors, walls, or oneself)
- Hoarding items (for fear of throwing away something important)
- Ordering (arranging and rearranging furniture or items on a desk or shelf into perfect order; vacuuming the rug pile in one direction)
- Exhibiting rigid performance (getting dressed in an unvarying pattern)
- Having aggressive urges (for instance, to throw one’s child against a wall)

Obsessive-compulsive disorder (OCD) is diagnosed only when these thoughts, images, and impulses consume the person or he or she is compelled to act out the behaviors to a point at which they interfere with personal, social, and occupational function. Examples include a man who can no longer work because he spends most of his day aligning blocks, desks in a classroom, or a woman who feels compelled to wash her hands after touching any object or person.

OCD can be manifested through many behaviors, all of which are repetitive, meaningless, and difficult to conquer. The person understands that these rituals are unusual and unreasonable but feels forced to perform them to alleviate anxiety or to prevent terrible thoughts. Obsessions and compulsions are a source of distress and shame to the person, who may go to great lengths to keep them secret.

**Onset and Clinical Course**

OCD can start in childhood, especially in males. In females, it more commonly begins in the twenties. Overall, distribution between the sexes is equal. Onset is usually gradual, although there have been cases of acute onset with periods of waxing and waning symptoms. Exacerbation of symptoms may be related to stress. Eighty percent of those treated with behavior therapy and medication report success in managing obsessions and compulsions, whereas 15% show progressive deterioration in occupational and social functioning (APA, 2000).

**Treatment**

Like other anxiety disorders, optimal treatment for OCD combines medication and behavior therapy. Table 13.3 lists drugs used to treat OCD. Behavior therapy specifically includes exposure and response prevention: Exposure involves assisting the client to deliberately confront the situations and stimuli that he or she usually avoids. Response prevention focuses on delaying or avoiding performance of rituals. The person learns to tolerate the anxiety and to recognize that it will recede without the disastrous imagined consequences. Other techniques discussed previously, such as deep breathing and relaxation, also can assist the person to tolerate and eventually manage the anxiety (Geffken et al., 2004).

**APPLICATION OF THE NURSING PROCESS: OBSESSIVE-COMPULSIVE DISORDER**

**Assessment**

Box 13.2 presents the Yale-Brown Obsessive-Compulsive Scale. The nurse can use this tool along with the following detailed discussion to guide his or her assessment of the client with OCD.

**HISTORY**

The client usually seeks treatment only when obsessions become too overwhelming, when compulsions interfere with daily life (e.g., going to work, cooking meals, participating in leisure activities with family or friends), or both. Clients are hospitalized only when they have become completely unable to carry out their daily routines. Most treatment is outpatient. The client often reports that rituals began many years before; some begin as early as childhood. The more responsibility the client has as he or she gets older, the more the rituals interfere with the ability to fulfill those responsibilities.

**GENERAL APPEARANCE AND MOTOR BEHAVIOR**

The nurse assesses the client’s appearance and behavior. Clients with OCD often seem tense, anxious, worried, and
### Box 13.2  
**Yale-Brown Obsessive-Compulsive Scale**

For each item circle the number identifying the response which best characterizes the patient.

1. **Time occupied by obsessive thoughts**
   - How much of your time is occupied by obsessive thoughts?
   - How frequently do the obsessive thoughts occur?
     - 0 None
     - 1 Mild (less than 1 h/day) or occasional (intrusion occurring no more than 8 times a day)
     - 2 Moderate (1–3 h/day) or frequent (intrusion occurring more than 8 times a day, but most of the hours of the day are free of obsessions)
     - 3 Severe (greater than 3 and up to 8 h/day) or very frequent (intrusion occurring more than 8 times a day and occurring during most of the hours of the day)
     - 4 Extreme (greater than 8 h/day) or near consistent intrusion (too numerous to count and an hour rarely passes without several obsessions occurring)

2. **Interference due to obsessive thoughts**
   - How much do your obsessive thoughts interfere with your social or work (or role) functioning?
   - Is there anything that you don’t do because of them?
     - 0 None
     - 1 Mild, slight interference with social or occupational activities, but overall performance not impaired
     - 2 Moderate, definite interference with social or occupational performance but still manageable
     - 3 Severe, causes substantial impairment in social or occupational performance
     - 4 Extreme, incapacitating

3. **Distress associated with obsessive thoughts**
   - How much distress do your obsessive thoughts cause you?
     - 0 None
     - 1 Mild, infrequent, and not too disturbing
     - 2 Moderate, frequent, and disturbing but still manageable
     - 3 Severe, very frequent, and very disturbing
     - 4 Extreme, near constant, and disabling distress

4. **Resistance against obsessions**
   - How much of an effort do you make to resist the obsessive thoughts?
   - How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?
     - 0 Makes an effort to always resist, or symptoms so minimal doesn’t need to actively resist
     - 1 Tries to resist most of the time
     - 2 Makes some effort to resist
     - 3 Yields to all obsessions without attempting to control them, but does so with some reluctance

5. **Degree of control over obsessive thoughts**
   - How much control do you have over your obsessive thoughts?
   - How successful are you in stopping or diverting your obsessive thinking?
     - 0 Complete control
     - 1 Much control, usually able to stop or divert obsessions with some effort and concentration
     - 2 Moderate control, sometimes able to stop or divert obsessions
     - 3 Little control, rarely successful in stopping obsessions
     - 4 No control, experienced as completely involuntary, rarely able to even momentarily divert thinking

6. **Time spent performing compulsive behaviors**
   - How much time do you spend performing compulsive behaviors?
   - How frequently do you perform compulsions?
     - 0 None
     - 1 Mild (less than 1 h/day performing compulsions) or occasional (performance of compulsions occurring no more than 8 times a day)
     - 2 Moderate (1–3 h/day performing compulsions) or frequent (performance of compulsions occurring more than 8 times a day, but most of the hours of the day are free of compulsive behaviors)
     - 3 Severe (greater than 3 and up to 8 h/day performing compulsions) or very frequent (performance of compulsions occurring more than 8 times a day and occurring during most of the hours of the day)
     - 4 Extreme (greater than 8 h/day performing compulsions) or near consistent performance of compulsions (too numerous to count and an hour rarely passes without several compulsions being performed)

7. **Interference due to compulsive behaviors**
   - How much do your compulsive behaviors interfere with your social or work (or role) functioning?
   - Is there anything that you don’t do because of the compulsions?
     - 0 None
     - 1 Mild, slight interference with social or occupational activities, but overall performance not impaired
     - 2 Moderate, definite interference with social or occupational performance but still manageable
     - 3 Severe, causes substantial impairment in social or occupational performance
     - 4 Extreme, incapacitating
8. Distress associated with compulsive behavior
   How would you feel if prevented from performing your compulsions?
   How anxious would you become? How anxious do you get while performing compulsions until you are satisfied they are completed?
   0 None
   1 Mild, only slightly anxious if compulsions prevented or only slightly anxious during performance of compulsions
   2 Moderate, reports that anxiety would mount but remain manageable if compulsions prevented or that anxiety increases but remains manageable during performance of compulsions
   3 Severe, prominent and very disturbing increase in anxiety if compulsions interrupted or prominent and very disturbing increases in anxiety during performance of compulsions
   4 Extreme, incapacitating anxiety from any intervention aimed at modifying activity or incapacitating anxiety develops during performance of compulsions

9. Resistance against compulsions
   How much of an effort do you make to resist the compulsions?
   0 Makes an effort to always resist, or symptoms so minimal doesn’t need to actively resist
   1 Tries to resist most of the time
   2 Makes some effort to resist
   3 Yields to all compulsions without attempting to control them but does so with some reluctance
   4 Completely and willingly yields to all compulsions

10. Degree of control over compulsive behavior
    0 Complete control
    1 Much control, experiences pressure to perform the behavior but usually able to exercise voluntary control over it
    2 Moderate control, strong pressure to perform behavior, can control it only with difficulty
    3 Little control, very strong drive to perform behavior, must be carried to completion, can only delay with difficulty
    4 No control, drive to perform behavior experienced as completely involuntary

fretful. They may have difficulty relating symptoms because of embarrassment. Their overall appearance is unremarkable, that is, nothing observable seems to be “out of the ordinary.” The exception is the client who is almost immobilized by her or his thoughts and the resulting anxiety.

**MOOD AND AFFECT**

During assessment of mood and affect, clients report ongoing, overwhelming feelings of anxiety in response to the obsessive thoughts, images, or urges. They may look sad and anxious.

**THOUGHT PROCESSES AND CONTENT**

The nurse explores the client’s thought processes and content. Many clients describe the obsessions as arising from nowhere during the middle of normal activities. The harder the client tries to stop the thought or image, the more intense it becomes. The client describes how these obsessions are not what he or she wants to think about and that he or she would never willingly have such ideas or images.

Assessment reveals intact intellectual functioning. The client may describe difficulty concentrating or paying atten-
tion when obsessions are strong. There is no impairment of memory or sensory functioning.

**JUDGMENT AND INSIGHT**

The nurse examines the client's judgment and insight. The client recognizes that the obsessions are irrational, but he or she cannot stop them. He or she can make sound judgments (e.g., “I know the house is safe”) but cannot act on them. The client still engages in ritualistic behavior when the anxiety becomes overwhelming.

**SELF-CONCEPT**

During exploration of self-concept, the client voices concern that he or she is “going crazy.” Feelings of powerlessness to control the obsessions or compulsions contribute to low self-esteem. The client may believe that if he or she were “stronger” or had more will power, he or she could possibly control these thoughts and behaviors.

**ROLES AND RELATIONSHIPS**

It is important for the nurse to assess the effects of OCD on the client's roles and relationships. As the time spent performing rituals increases, the client's ability to fulfill life roles successfully decreases. Relationships also suffer as family and friends tire of the repetitive behavior, and the client is less available to them as he or she is more consumed with anxiety and ritualistic behavior.

**PHYSIOLOGIC AND SELF-CARE CONSIDERATIONS**

The nurse examines the effects of OCD on physiology and self-care. As with other anxiety disorders, clients with OCD may have trouble sleeping. Performing rituals may take time away from sleep, or anxiety may interfere with the ability to go to sleep and wake refreshed. Clients also may report a loss of appetite or unwanted weight loss. In severe cases, personal hygiene may suffer because the client cannot complete needed tasks.

**Data Analysis**

Depending on the particular obsession and its accompanying compulsions, clients have varying symptoms. Nursing diagnoses can include the following:

- Anxiety
- Ineffective Coping
- Fatigue
- Situational Low Self-Esteem
- Impaired Skin Integrity (if scrubbing or washing rituals)

**Outcome Identification**

Outcomes for clients with OCD include the following:

- The client will demonstrate effective use of relaxation techniques.
- The client will discuss feelings with another person.
- The client will demonstrate effective use of behavior therapy techniques.
- The client will spend less time performing rituals.

**Intervention**

**USING THERAPEUTIC COMMUNICATION**

Offering support and encouragement to the client is important to help him or her manage anxiety responses. The nurse can validate the overwhelming feelings the client experiences while indicating the belief that the client can make needed changes and regain a sense of control. The nurse encourages the client to talk about the feelings and to describe them in as much detail as the client can tolerate. Because many clients try to hide their rituals and to keep obsessions secret, discussing these thoughts, behaviors, and resulting feelings with the nurse is an important step. Doing so can begin to relieve some of the “burden” the client has been keeping to himself or herself.

**TEACHING RELAXATION AND BEHAVIORAL TECHNIQUES**

The nurse can teach the client about relaxation techniques such as deep breathing, progressive muscle relaxation, and guided imagery. This intervention should take place when the client's anxiety is low so he or she can learn more effectively. Initially, the nurse can demonstrate and practice the techniques with the client. Then, the nurse encourages the client to practice these techniques until he or she is comfortable doing them alone. When the client has mastered relaxation techniques, he or she can begin to use them when anxiety increases. In addition to decreasing anxiety, the client gains an increased sense of control that can lead to improved self-esteem.

To manage anxiety and ritualistic behaviors, a baseline of frequency and duration is necessary. The client can keep a diary to chronicle situations that trigger obsessions, the intensity of the anxiety, the time spent performing rituals, and the avoidance behaviors. This record provides a clear picture for both client and nurse. The client then can begin to use exposure and response prevention behavioral techniques. Initially, the client can decrease the time he or she spends performing the ritual or delay performing the ritual while experiencing anxiety. Eventually, the client can eliminate the ritualistic response or decrease it significantly to the point that interference with daily life is minimal. Clients can use relaxation techniques to assist them in managing and tolerating the anxiety they are experiencing.

It is important to note that the client must be willing to engage in exposure and response prevention. These are not techniques that can be forced on the client.
COMPLETING A DAILY ROUTINE

To accomplish tasks efficiently, the client initially may need additional time to allow for rituals. For example, if breakfast is at 8:00 AM and the client has a 45-minute ritual before eating, the nurse must plan that time into the client’s schedule. It is important for the nurse not to interrupt or to attempt to stop the ritual because doing so will escalate the client’s anxiety dramatically. Again, the client must be willing to make changes in his or her behavior. The nurse and client can agree on a plan to limit the time spent performing rituals. They may decide to limit the morning ritual to 40 minutes, then to 35 minutes, and so forth, taking care to decrease this time gradually at a rate the client can tolerate. When the client has completed the ritual or the time allotted has passed, the client then must engage in the expected activity. This may cause anxiety and is a time when the client can use relaxation and stress reduction techniques. At home, the client can continue to follow a daily routine or written schedule that helps him or her to stay on tasks and accomplish activities and responsibilities.

PROVIDING CLIENT AND FAMILY EDUCATION

It is important for both the client and family to learn about OCD. They often are relieved to find the client is not “going crazy” and that the obsessions are unwanted, rather than a reflection of any “dark side” to the client’s personality. Helping the client and family to talk openly about the obsessions, anxiety, and rituals eliminates the client’s need to keep these things secret and to carry the guilty burden alone. Family members also can better give the client needed emotional support when they are fully informed.

NURSING INTERVENTIONS FOR OCD

- Offer encouragement, support, and compassion.
- Be clear with the client that you believe he or she can change.
- Encourage the client to talk about feelings, obsessions, and rituals in detail.
- Gradually decrease time for the client to carry out ritualistic behaviors.
- Assist client to use exposure and response prevention behavioral techniques.
- Encourage client to use techniques to manage and tolerate anxiety responses.
- Assist client to complete daily routine and activities within agreed-on time limits.
- Encourage the client to develop and follow a written schedule with specified times and activities.

CLIENT/FAMILY EDUCATION FOR OCD

- Teach about OCD.
- Review the importance of talking openly about obsessions, compulsions, and anxiety.
- Emphasize medication compliance as an important part of treatment.
- Discuss necessary behavioral techniques for managing anxiety and decreasing prominence of obsessions.

Teaching about the importance of medication compliance to combat OCD is essential. The client may need to try different medications until his or her response is satisfactory. The chances for improved OCD symptoms are enhanced when the client takes medication and uses behavioral techniques.

Evaluation

Treatment has been effective when OCD symptoms no longer interfere with the client’s ability to carry out responsibilities. When obsessions occur, the client manages resulting anxiety without engaging in complicated or time-consuming rituals. He or she reports regained control over his or her life and the ability to tolerate and manage anxiety with minimal disruption.

GENERALIZED ANXIETY DISORDER

A person with generalized anxiety disorder (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 psychiatrists. The quality of life is diminished greatly in older adults with GAD. Buspirone (BuSpar) and SSRI antidepressants are the most effective treatments (Starcevic, 2006).

POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder can occur in a person who has witnessed an extraordinarily terrifying and potentially deadly event. After the traumatic event, the person re-experiences all or some of it through dreams or waking recollections and responds defensively to these flashbacks. New behaviors develop related to the trauma, such as sleep difficulties, hypervigilance, thinking difficulties, severe startle response, and agitation (APA, 2000; see Chapter 11).
ACUTE STRESS DISORDER

Acute stress disorder is similar to posttraumatic stress disorder in that the person has experienced a traumatic situation but the response is more dissociative. The person has a sense that the event was unreal, believes he or she is unreal, and forgets some aspects of the event through amnesia, emotional detachment, and muddled obliviousness to the environment (APA, 2000).

SELF-AWARENESS ISSUES

Working with people who have anxiety disorders is a different kind of challenge for the nurse. These clients are usually average people in other respects who know that their symptoms are unusual but feel unable to stop them. They experience much frustration and feelings of helplessness and failure. Their lives are out of their control, and they live in fear of the next episode. They go to extreme measures to try to prevent episodes by avoiding people and places where previous events occurred.

It may be difficult for nurses and others to understand why the person cannot simply stop performing the bizarre behaviors interfering with his or her life. Why does the hand-washer who has scrubbed himself raw keep washing his poor sore hands every hour on the hour? Nurses must understand what and how anxiety behaviors work, not just for client care but to help understand the role anxiety plays in performing nursing responsibilities. Nurses are expected to function at a high level and to avoid allowing their own feelings and needs to hinder the care of their clients. But as emotional beings, nurses are just as vulnerable to stress and anxiety as others, and they have needs of their own.

Points to Consider When Working With Clients With Anxiety and Stress-Related Illness

- Remember that everyone occasionally suffers from stress and anxiety that can interfere with daily life and work.
- Avoid falling into the pitfall of trying to “fix” the client’s problems.
- Discuss any uncomfortable feelings with a more experienced nurse for suggestions on how to deal with your feelings toward these clients.
- Remember to practice techniques to manage stress and anxiety in your own life.

Critical Thinking Questions

1. Because all people occasionally have anxiety, it is important for nurses to be aware of their own coping mechanisms. Do a self-assessment: What causes you anxiety? What physical, emotional, and cognitive

responses occur when you are anxious? What coping mechanisms do you use? Are they healthy?

2. Some clients take benzodiazepine anxiolytics for months or even years even though these medications are designed for short-term use. Why does this happen? What, if anything, should be done for these clients? How would you approach the situation?

KEY POINTS

- 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 has positive and negative side effects. The positive effects produce growth and adaptive change. The negative effects produce poor self-esteem, fear, inhibition, and anxiety disorders (in addition to other disorders).
- The four levels of anxiety are mild anxiety (helps people learn, grow, and change); moderate anxiety (increases focus on the alarm; learning is still possible); severe anxiety (greatly decreases cognitive function, increases preparation for physical responses, increases space needs); and panic (fight, flight, or freeze response; no learning is possible; the person is attempting to free him or herself from the discomfort of this high stage of anxiety).
- Defense mechanisms are intrapsychic distortions that a person uses to feel more in control. It is believed that these defense mechanisms are overused when a person develops an anxiety disorder.
- Current etiologic theories and studies of anxiety disorders have shown a familial incidence and have implicated the neurotransmitters GABA, norepinephrine, and serotonin.
- Treatment for anxiety disorders involves medication (anxiolytics, SSRI and tricyclic antidepressants, and clonidine and propranolol) and therapy.
- Cognitive-behavioral techniques include positive reframing, decatastrophizing, thought stopping, and distraction. Behavioral techniques for OCD include exposure and response prevention.
- In a panic attack, the person feels as if he or she is dying. Symptoms can include palpitations, sweating, tremors, shortness of breath, a sense of suffocation, chest pain, nausea, abdominal distress, dizziness, paresthesias, and vasomotor lability. The person has a fight, flight, or freeze response.
- Phobias are excessive anxiety about being in public or open places (agoraphobia), a specific object, or social situations.
- OCD involves recurrent, persistent, intrusive, and unwanted thoughts, images, or impulses (obsessions) and ritualistic or repetitive behaviors or mental acts (com-
pulsions) carried out to eliminate the obsessions or to neutralize anxiety.
• Self-awareness about one’s anxiety and responses to it greatly improves both personal and professional relationships.

REFERENCES

ADDITIONAL READINGS
MULTIPLE-CHOICE QUESTIONS

Select the best answer for each of the following questions.

1. The nurse observes a client who is becoming increasingly upset. He is rapidly pacing, hyperventilating, clenching his jaw, wringing his hands, and trembling. His speech is high-pitched and random; he seems preoccupied with his thoughts. He is pounding his fist into his other hand. The nurse identifies his anxiety level as
   A. Mild
   B. Moderate
   C. Severe
   D. Panic

2. When assessing a client with anxiety, the nurse's questions should be
   A. Avoided until the anxiety is gone
   B. Open ended
   C. Postponed until the client volunteers information
   D. Specific and direct

3. During the assessment, the client tells the nurse that she cannot stop worrying about her appearance and that she often removes “old” makeup and applies fresh makeup every hour or two throughout the day. The nurse identifies this behavior as indicative of a(n)
   A. Acute stress disorder
   B. Generalized anxiety disorder
   C. Panic disorder
   D. Obsessive-compulsive disorder

4. The best goal for a client learning a relaxation technique is that the client will
   A. Confront the source of anxiety directly
   B. Experience anxiety without feeling overwhelmed
   C. Report no episodes of anxiety
   D. Suppress anxious feelings

5. Which of the four classes of medications used for panic disorder is considered the safest because of low incidence of side effects and lack of physiologic dependence?
   A. Benzodiazepines
   B. Tricyclics
   C. Monoamine oxidase inhibitors
   D. Selective serotonin reuptake inhibitors

6. Which of the following would be the best intervention for a client having a panic attack?
   A. Involve the client in a physical activity.
   B. Offer a distraction such as music.
   C. Remain with the client.
   D. Teach the client a relaxation technique.

7. A client with generalized anxiety disorder states, “I have learned that the best thing I can do is to forget my worries.” How would the nurse evaluate this statement?
   A. The client is developing insight.
   B. The client’s coping skills have improved.
   C. The client needs encouragement to verbalize feelings.
   D. The client’s treatment has been successful.

8. A client with anxiety is beginning treatment with lorazepam (Ativan). It is most important for the nurse to assess the client’s
   A. Motivation for treatment
   B. Family and social support
   C. Use of coping mechanisms
   D. Use of alcohol

FILL-IN-THE-BLANK QUESTIONS

Identify the level of anxiety represented by the following descriptions.

1. Severe muscle tension, limited perceptual field, frantic
2. Attentive, impatient, optimal learning level
3. Flight, fight, or freeze; out of control; irrational
4. Selective inattention, voice changes, decreased perceptual field
SHORT-ANSWER QUESTIONS

1. Discuss the concepts of primary and secondary gain; give an example of each.

2. Describe systematic desensitization.

CLINICAL EXAMPLE

Mr. Noe has discussed in detail with the community health nurse how his wife cannot be expected to walk 2 to 3 miles a day after her triple-bypass operation because she is afraid to leave the house. He has been taking care of her for the past 13 years, during which time she has rarely left the house and then only with great distress and only accompanied by him. His wife says she gets so anxious she wants to scream and run back in the door if she tries to walk out of it. She believes something terrible will happen to her. She knows this is true because the last time she left the house to go to the doctor, she had to have triple-bypass surgery the next day. Mr. Noe takes care of necessary chores outside the house, attends parents’ weekends at their children’s colleges, does the grocery shopping, and so forth.

Mrs. Noe has asked the nurse to “figure out how I can get outside and walk every day,” but for each suggestion the nurse makes, Mrs. Noe finds some reason it will not work. The nurse is getting frustrated with Mrs. Noe’s constant rejection of her suggestions and sternly says, “If you aren’t going to try any of my suggestions, then I guess we’re wasting our time.”

1. Rather than giving Mrs. Noe suggestions to get her outside, what might be a better plan?
2. How is Mr. Noe's behavior affecting Mrs. Noe's agoraphobia? What does the nurse need to explain and to recommend to Mr. Noe about his response to her behavior?

3. What other treatments are available for Mrs. Noe?