Did you ever suspect that one of your friends or family members had an emotional or psychiatric problem but dismissed the idea as impossible? Have you thought that most people with psychiatric problems were suffering from schizophrenia? Have you ever worried about the barometer of your own mental health but felt embarrassed to discuss it? If you have answered “yes” to any of these questions, you are in for an awakening.

The fact is that almost half of all people in the United States experience some type of psychiatric problem in their lifetime. Anxiety disorders, mood disorders, and substance use disorders are by far the most common psychiatric disorders, and they are experienced by people more often than many physical illnesses. They are disabling disorders that cause people significant distress, yet they are often underdiagnosed and undertreated. These facts are more than just interesting. They suggest that health care professionals need a wide variety of educational and treatment strategies to address these issues.

This unit will explore the adaptive and maladaptive coping responses used by people experiencing stress. Some of what you read will surprise you, some of it will concern you, and it is hoped that most of it will intrigue you. It is important that you understand, however, that these psychiatric problems are a common part of the human experience. As such, they merit careful study and consideration by nurses such as you.
Anxiety Responses and Anxiety Disorders

Gail W. Stuart

Learning Objectives
1. Describe the continuum of adaptive and maladaptive anxiety responses.
2. Identify behaviors associated with anxiety responses.
3. Analyze predisposing factors, precipitating stressors, and appraisal of stressors related to anxiety responses.
4. Describe coping resources and coping mechanisms related to anxiety responses.
5. Formulate nursing diagnoses related to anxiety responses.
6. Examine the relationship between nursing diagnoses and medical diagnoses related to anxiety responses.
7. Identify expected outcomes and short-term nursing goals related to anxiety responses.
8. Develop a patient education plan to promote the relaxation response.
10. Evaluate nursing care related to anxiety responses.

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Anxiety is a part of everyday life. It has always existed and belongs to no particular era or culture. Anxiety involves one’s body, perceptions of self, and relationships with others, making it a basic concept in the study of psychiatric nursing and human behavior.

Anxiety disorders are the most common psychiatric disorders in the United States, affecting between 15% and 25% of the population. Those with an anxiety disorder have significant impairment in quality of life and functioning (Rapaport et al, 2005).

It has been estimated that only about 25% of those with anxiety disorders receive treatment. However, these people are high users of health care facilities because they seek treatment for the various symptoms caused by anxiety, such as chest pain, palpitations, dizziness, and shortness of breath.

CONTINUUM OF ANXIETY RESPONSES

Anxiety is a diffuse apprehension that is vague in nature and associated with feelings of uncertainty and helplessness. Feelings of isolation, alienation, and insecurity are also present. The person perceives that the core of his personality is being threatened. Experiences provoking anxiety begin in infancy and continue throughout life. They end with the fear of the greatest unknown, death.

Defining Characteristics
Anxiety is an emotion and a subjective individual experience. It is an energy and cannot be observed directly. A nurse infers that a patient is anxious based on certain behaviors. The nurse needs to validate this inference with the patient.
Anxiety is an emotion without a specific object. It is provoked by the unknown and precedes all new experiences, such as entering school, starting a new job, or giving birth to a child. This characteristic of anxiety differentiates it from fear.

Fear has a specific source or object that the person can identify and describe. Fear involves the intellectual appraisal of a threatening stimulus; anxiety is the emotional response to that appraisal. A fear is caused by physical or psychological exposure to a threatening situation. Fear produces anxiety. These two emotions are differentiated in speech; we speak of having a fear but of being anxious.

Anxiety is communicated interpersonally. If a nurse is talking with a patient who is anxious, within a short time the nurse also will experience feelings of anxiety. Similarly, if a nurse is anxious in a particular situation, this anxiety will be communicated to the patient.

The contagious nature of anxiety therefore can have positive and negative effects on the therapeutic relationship. The nurse must carefully monitor these effects. It is also important to remember that anxiety is part of everyday life. It is basic to the human condition and provides a valuable warning. In fact, the capacity to be anxious is necessary for survival.

The crux of anxiety is self-preservation. Anxiety occurs as a result of a threat to a person’s selfhood, self-esteem, or identity. It results from a threat to something central to one’s personality and essential to one’s existence and security. It may be connected with the fear of punishment, disapproval, withdrawal of love, disruption of a relationship, isolation, or loss of body functioning.

Culture is related to anxiety because culture can influence the values one considers most important. Underlying every fear is the anxiety of losing one’s own being. This anxiety is the frightening element, but a person can encompass the anxiety and grow from it to the extent that the person confronts, moves through, and overcomes anxiety-creating experiences.

**Critical Thinking** Name two situations that provoke anxiety in you. Compare these with two situations that stimulate fear in you.

### Levels of Anxiety

Peplau (1963) identified four levels of anxiety and described their effects:

1. **Mild anxiety is associated with the tension of day-to-day living.** During this stage the person is alert and the perceptual field is increased. The person sees, hears, and grasps more than before. This kind of anxiety can motivate learning and produce growth and creativity.

2. **Moderate anxiety, in which the person focuses only on immediate concerns, involves the narrowing of the perceptual field.** The person sees, hears, and grasps less. The person blocks selected areas but can attend to more if directed to do so.

3. **Severe anxiety is marked by a significant reduction in the perceptual field.** The person tends to focus on a specific detail and not think about anything else. All behavior is aimed at relieving anxiety, and much direction is needed to focus on another area.

4. **Panic is associated with awe, dread, and terror, and the person feeling it is unable to do things even with direction. Panic involves the disorganization of the personality and can be life threatening.** Increased motor activity, decreased ability to relate to others, distorted perceptions, and loss of rational thought are all symptoms of panic. Panic is a frightening and paralyzing experience. The panicked person is unable to communicate or function effectively. This level of anxiety cannot persist indefinitely because it is incompatible with life. A prolonged period of panic would result in exhaustion and death. It is a common and debilitating phenomenon, but it can be safely and effectively treated.

The nurse needs to be able to identify which level of anxiety a patient is experiencing by the behaviors observed. Figure 15-1 shows the range of anxiety responses from the most adaptive response of anticipation to the most maladaptive response of panic. The patient’s level of anxiety and its position on the continuum of coping responses are relevant to the nursing diagnosis and influence the type of intervention the nurse implements.

### ASSESSMENT

**Behaviors**

Anxiety can be expressed directly through physiological and behavioral changes or indirectly through cognitive and affective responses, including the formation of symptoms or coping mechanisms developed as a defense against anxiety. The nature of the responses displayed depends on the level of anxiety, and the intensity of the response increases with increasing anxiety.

In describing anxiety’s effects on physiological responses, mild anxiety and moderate anxiety heighten the person’s capacities.
Conversely, severe anxiety and panic levels paralyze or overwork capacities. The physiological responses associated with anxiety are modulated primarily by the brain through the autonomic nervous system (Figure 15-2). The body adjusts internally without a conscious or voluntary effort. Two types of autonomic responses exist:

1. **Parasympathetic** responses, which conserve body responses
2. **Sympathetic** responses, which activate body processes

Studies support the predominance of the sympathetic reaction in anxiety responses. This reaction prepares the body to deal with an emergency situation by a fight-or-flight reaction. It can also trigger the general adaptation syndrome, as described by Selye.
Anxiety is an unpleasant and uncomfortable experience that most people try to avoid. They often try to replace anxiety with a more tolerable feeling. Pure anxiety is rarely seen. Anxiety is usually observed in combination with other emotions.

Patients might describe feelings of anger, boredom, contempt, depression, irritation, worthlessness, jealousy, self-depreciation, suspicion, sadness, or helplessness. This combination of emotions makes it difficult for the nurse to discriminate between anxiety and depression, for instance, because the patient’s descriptions may be similar.

Close ties exist among anxiety, depression, guilt, and hostility. These emotions often function reciprocally; one feeling acts to generate and reinforce the others. The relationship between anxiety and hostility is particularly close. The pain experienced with anxiety often causes anger and resentment toward those thought to be responsible. These feelings of hostility in turn increase anxiety.

This cycle was evident in the case of a highly anxious, dependent, and insecure wife who was very attached to her husband. In exploring her feelings she also expressed great hostility toward him and their relationship. Verbalizing these angry feelings further increased her anxiety and unresolved conflict. Thus anxiety is often expressed through anger, and a tense and anxious person is more likely to become angry.

**Critical Thinking** Think of a patient you cared for recently who appeared to be angry or critical. Could this have been the patient’s way of dealing with anxiety? If so, how would your nursing interventions have differed?
Predisposing Factors

Biological. The majority of studies point to a dysfunction in multiple systems rather than isolating one particular neurotransmitter in the development of an anxiety disorder. These systems include the following:

- **GABA system.** The regulation of anxiety is related to the activity of the neurotransmitter gamma-aminobutyric acid (GABA), which controls the activity, or firing rates, of neurons in the parts of the brain responsible for producing anxiety. **GABA is the most common inhibitory neurotransmitter in the brain.**

  When it crosses the synapse and attaches or binds to the GABA receptor on the postsynaptic membrane, the receptor channel opens, allowing for the exchange of ions. This exchange results in an inhibition or reduction of cell excitability and thus a slowing of cell activity. The theory is that people who have an excess of anxiety have a problem with the efficiency of this neurotransmission process.

  When a person with anxiety takes a benzodiazepine (BZ) medication, which is from the antianxiety class of drugs, it binds to a place on the GABA receptor next to GABA. This makes the postsynaptic receptor more sensitive to the effects of GABA, enhancing neurotransmission and causing even more inhibition of cell activity (Figure 15-3).

  The effect of GABA and BZ at the GABA receptor in various parts of the brain is a reduced firing rate of cells in areas implicated in anxiety disorders. The clinical result is that the person becomes less anxious.

  The areas of the brain where GABA receptors are coupled to BZ receptors include the **amygdala and hippocampus, both structures of the limbic system,** which functions as the center of emotions (e.g., rage, arousal, fear) and memory.

Patients with anxiety disorders may have a decreased antianxiety ability of the GABA receptors in areas of the limbic system, making them more sensitive to anxiety and panic.

- **Norepinephrine system.** The norepinephrine (NE) system is thought to mediate the fight-or-flight response. The part of the brain that manufactures NE is the **locus ceruleus.** It is connected by neurotransmitter pathways to other structures of the brain associated with anxiety, such as the amygdala, the hippocampus, and the cerebral cortex (the thinking, interpreting, and planning part of the brain).

  Medications that decrease the activity of the locus ceruleus (antidepressants such as the tricyclics) effectively treat some anxiety disorders. This suggests that anxiety may be caused in part by an inappropriate activation of the NE system in the locus ceruleus and an imbalance between NE and other neurotransmitter systems.

- **Serotonin system.** A dysregulation of serotonin (5-HT) neurotransmission may play a role in the etiology of anxiety, because patients experiencing these disorders may have hypersensitive 5-HT receptors.

  Drugs that regulate serotonin, such as the selective serotonin reuptake inhibitors (SSRIs), have been shown to be particularly effective in treating several of the anxiety disorders, suggesting a major role for 5-HT and its balance with other neurotransmitter systems in the etiology of anxiety disorders.

  Evidence suggests that **traumatic experiences** may change the brain and the ways in which it responds to subsequent stressors. Research shows that the effects of trauma involve alterations in many regions of the brain, particularly the limbic system. The hypothalamic-pituitary-adrenal (HPA) axis, a major response system, also appears to be modified by trauma, as do the neu-

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**Figure 15-3** Effects of benzodiazepine (BZ) drug at the gamma-aminobutyric acid (GABA) receptor. Cl\(^{-}\), Chloride ion.
to anxiety.

Keltner and Dowben, 2007; Weiss, 2007). Transmitters discussed above (Olszewski and Varrasse, 2005; impairment by toxic influences, dietary deficiencies, reduced blood supply, hormonal changes, and other physical causes. In addition, symptoms from some physical disorders may mimic or exacerbate symptoms from some physical disorders.

Anxiety may accompany some physical disorders, such as those listed in Box 15-2. Coping mechanisms also may be impaired by toxic influences, dietary deficiencies, reduced blood supply, hormonal changes, and other physical causes. In addition, symptoms from some physical disorders may mimic or exacerbate anxiety.

Similarly, fatigue increases irritability and feelings of anxiety. It appears that fatigue caused by nervous factors predisposes the person to a greater degree of anxiety than does fatigue caused by purely physical causes. Thus fatigue may actually be an early symptom of anxiety. Patients with nervous fatigue and sleep problems may already be experiencing moderate anxiety and be more susceptible to future stress situations.

Familial. Epidemiological and family studies show that anxiety disorders run in families and that they are common and of different types. For example, the heritability of panic disorder is estimated to be about 40%. Individuals with a family history of psychiatric illness are three times more likely to develop post-traumatic stress disorder (PTSD) following a traumatic event.

Despite strong evidence for genetic susceptibility, no single or specific gene has been clearly identified for anxiety disorders. This is due, in part, to the critical role that the environment plays in modulating genetic susceptibility in mental disorders.

Anxiety disorders can overlap, as do anxiety disorders and depression. People with one anxiety disorder are more likely to develop another or to experience a major depression within their lifetime.

Psychological. Learning theorists believe that people who have been exposed in early life to intense fears are more likely to be anxious in later life. Thus parental influences are important. Children who see their parents react with anxiety to every minor stress soon develop a similar pattern. In contrast, if parents are completely unmoved by potentially stressful situations, children feel alone and lack emotional support from their families. The appropriate emotional response of parents gives children security and helps them learn constructive coping methods.

A person’s level of self-esteem is an important factor related to anxiety. A person who is easily threatened or has a low level of self-esteem is more susceptible to anxiety. This is seen in students with test anxiety. Anxiety is high because they doubt they can succeed. This anxiety may have nothing to do with their actual abilities or how much they studied. The anxiety is caused only by their perception of their ability, which reflects their self-concept. They may be well prepared for the examination, but their severe level of anxiety reduces their perceptual field significantly. They may omit, misinterpret, or distort the meaning of the test items. They may even block out all their previous studying. The result will be a poor grade, which reinforces their poor perception of self.

Perhaps the most important psychological trait is resilience to stress. Resilience is the ability to maintain normal functioning despite adversity. Resilience is associated with a number of protective psychosocial factors, including active coping style, positive outlook, interpersonal relatedness, moral compass, social support, role models, and cognitive flexibility.

Undertaking and mastering difficult tasks appear to be an effective way to increase one’s resilience to stress. For example, men and women who successfully managed stressful situations in childhood, such as death or illness of a parent or sibling, family relocation, or loss of friendship, are more resistant to adult stressors, such as divorce, death, major illness, or job loss.

Conversely, individuals who experienced extreme childhood stress that they could not control or master, such as physical or sexual abuse, may be more vulnerable to future stressors (Storr et al, 2007).

Critical Thinking How would you rate yourself on the protective psychosocial factors associated with resilience?

Behavioral. Some behavioral theorists propose that anxiety is a product of frustration caused by anything that interferes with attaining a desired goal. An example of an external frustration might be the loss of a job. Many goals may thus be blocked, such as financial security, pride in work, and perception of self as family provider. An internal frustration is evidenced by young college graduates who set unrealistically high career goals and are frustrated by entry-level job offers. In this case their view of self is...
threatened by their unrealistic goals. They are likely to experience feelings of failure, insignificance, and mounting anxiety.

Anxiety also may arise through conflict that occurs when a person experiences two competing drives and must choose between them. A reciprocal relationship exists between conflict and anxiety. Conflict produces anxiety, and anxiety increases the perception of conflict by producing feelings of helplessness.

In this view conflict derives from two tendencies: approach and avoidance. Approach is the tendency to do something or move toward something. Avoidance is the opposite tendency: not to do something or not to move toward something. There are four kinds of conflict:

1. **Approach-approach**, in which the person wants to pursue two equally desirable but incompatible goals. An example is having two very attractive job offers. This type of conflict seldom produces anxiety.

2. **Approach-avoidance**, in which the person wishes to both pursue and avoid the same goal. The patient who wants to express anger but feels great anxiety and fear in doing so experiences this type of conflict. Another example is the ambitious business executive who must compromise values of honesty and loyalty to be promoted.

3. **Avoidance-avoidance**, in which the person must choose between two undesirable goals. Because neither alternative seems beneficial, this is a difficult choice usually accompanied by much anxiety. An example is when a person observes a friend cheating and feels the need to report the act but worries about the loss of friends that might result from reporting the violation.

4. **Double approach-avoidance**, in which the person can see both desirable and undesirable aspects of both alternatives. An example of this is the conflict experienced by a person living with the pain of an unsatisfying social and emotional life, coupled with destructive coping patterns. The alternative is to seek psychiatric help and expose oneself to the threat and potential pain of the therapy process. Double approach-avoidance conflict feelings often are described as ambivalence.

**Critical Thinking** Think of an example of each of the four kinds of conflict that you have experienced in your own life.

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**Precipitating Stressors**

**Experiencing or witnessing trauma** has been associated with a variety of anxiety disorders, particularly posttraumatic stress disorder (PTSD). Most traumatized individuals experience more than one trauma in their lifetime, and the risk of PTSD increases with each event (Gill and Page, 2006). It has been estimated that PTSD occurs in about 14% of those exposed to traumatic events.

Epidemiological studies suggest that the majority of individuals involved in traumatic events will not develop a psychological disorder (Bisson et al, 2007a). The so-called “normal” response is highly variable. Some people will develop a marked initial reaction that resolves over a few weeks. Others will have little or no initial reaction and will not develop any difficulties. However, a minority will develop mental health problems that require intervention.

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**Box 15-3 Primary Care Posttraumatic Stress Disorder (PTSD) Screen**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting, that in the past month, you . . .

1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from things, activities, or your surroundings?

*Screen is positive if patient answers “yes” to any three items.

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With the return of soldiers serving in wars and the increasing violence in society, PTSD is becoming a more prevalent and impairing condition. Specifically, the detrimental effects of combat are deep and enduring, and veterans with combat stress reaction may be six times more likely to develop PTSD (Solomon and Mikulincer, 2006). One study found that soldiers who were severely injured were more likely to develop PTSD or depression and that soldiers with PTSD at 7 months did not meet criteria for the condition at 1 month (Grieger et al, 2006).

An individual at risk for PTSD should be screened using the primary care tool presented in Box 15-3. It focuses on the core PTSD symptom clusters. Anyone answering “yes” to three of the four items should have a more formal assessment (Friedman, 2006).

Maturational and situational crises, as described in Chapter 13, also can precipitate a maladaptive anxiety response. In total, precipitating stressors can be grouped into two categories: threats to physical integrity and threats to self-system.

**Threats to Physical Integrity.** Threats to physical integrity suggest impending physiological disability or decreased ability to perform activities of daily living. They may come from both internal and external sources. External sources may include exposure to viral and bacterial infection, environmental pollutants, and safety hazards; lack of adequate housing, food, or clothing; and traumatic injury.

Internal sources may include the failure of physiological mechanisms, such as the heart, immune system, or temperature regulation. The normal biological changes that can occur with pregnancy and failure to participate in preventive health practices are other internal sources. **Pain** is often the first indication that physical integrity is being threatened. It creates anxiety that often motivates the person to seek health care.

**Threats to Self-System.** Threats to one’s self-system imply harm to a person’s identity, self-esteem, and integrated social functioning. Both external and internal sources can threaten self-esteem.

External sources may include the loss of a valued person through death, divorce, or relocation; a change in job status; an ethical dilemma; and social or cultural group pressures. Work stress,
including excessive workload and extreme time pressures, has been found to precipitate anxiety and depression in previously healthy young workers (Melchior et al, 2007).

Internal sources may include interpersonal difficulties at home or at work or when assuming a new role, such as parent, student, or employee. In addition, many threats to physical integrity also threaten self-esteem because the mind-body relationship is an overlapping one.

This distinction of categories is only theoretical. The person responds to all stressors, whatever their nature and origin, as an integrated whole. No specific event is equally stressful to all people or even to the same person at different times.

**Appraisal of Stressors**

A true understanding of anxiety requires integration of knowledge from all the various points of view. The Stuart Stress Adaptation Model integrates data from psychoanalytical, interpersonal, behavioral, genetic, and biological perspectives, suggesting a variety of interrelated, causative factors as described in Box 15-4.

**Coping Resources**

The person can cope with stress and anxiety by mobilizing coping resources found internally and in the environment. Resources such as economic assets, problem-solving abilities, social supports, and cultural beliefs can help people integrate stressful experiences into their being and learn to adopt successful coping strategies. They also help people extract meaning from stressful experiences and foster the suggestion of alternative strategies for mediating stressful events.

- **Critical Thinking** How might a person’s religious or spiritual belief system serve as a resource in coping with a moderate level of anxiety?

**Coping Mechanisms**

As anxiety increases to the severe and panic levels, the behaviors displayed by a person become more intense and potentially injurious, and quality of life decreases. People seek to avoid anxiety and the circumstances that produce it. When experiencing anxiety, people use various coping mechanisms to try to relieve it (Box 15-5).

The inability to cope with anxiety constructively is a primary cause of pathological behavior. The pattern used to cope with mild anxiety dominates when anxiety becomes more intense. Anxiety plays a major role in the expression of emotional illness because many symptoms of illness develop as attempted defenses against anxiety.

The nurse needs to be familiar with the coping mechanisms people use when experiencing the various levels of anxiety. For mild anxiety, caused by the tension of day-to-day living, several coping mechanisms commonly used include crying, sleeping, eating, yawning, laughing, cursing, physical exercise, and daydreaming. Oral behavior, such as smoking and drinking, is another means of coping with mild anxiety.

When dealing with other people, the individual copes with low levels of anxiety through superficiality, lack of eye contact, use of clichés, and limited self-disclosure. People also can protect themselves from anxiety by assuming comfortable roles and limiting close relationships to those with values similar to their own.

Moderate, severe, and panic levels of anxiety pose greater threats to the ego. They require more energy to cope with the threat. These coping mechanisms can be categorized as problem or task focused and as emotion or ego focused.

**Problem- or Task-Focused Coping.** Problem- or task-focused coping mechanisms are thoughtful, deliberate attempts to solve problems, resolve conflicts, and gratify needs. These reactions can include attack, withdrawal, and compromise. They are aimed at realistically meeting the demands of a stress situation that has been objectively appraised. They are consciously directed and action oriented.

In **attack behavior** a person attempts to remove or overcome obstacles to satisfy a need. There are many possible ways of attacking problems, and this type of reaction may be destructive or
constructive. Destructive patterns are usually accompanied by great feelings of anger and hostility. These feelings may be expressed by negative or aggressive behavior that violates the rights, property, and well-being of others. Constructive patterns reflect a problem-solving approach. They are evident in self-assertive behaviors that respect the rights of others.

Withdrawal behavior may be expressed physically or psychologically. Physically, withdrawal involves removing oneself from the source of the threat. This reaction can apply to biological stressors, such as smoke-filled rooms, exposure to irradiation, or contact with contagious diseases. A person also can withdraw in various psychological ways, such as by admitting defeat, becoming apathetic, or lowering aspirations. As with attack, this type of reaction may be constructive or destructive. When it isolates the person from others and interferes with the ability to work, the reaction creates additional problems.

Compromise is necessary in situations that cannot be resolved through attack or withdrawal. This reaction involves changing usual ways of operating, substituting goals, or sacrificing aspects of personal needs. Compromise reactions are usually constructive and are often used in approach-approach and avoidance-avoidance situations. Occasionally, however, the person realizes with time that the compromise is not acceptable; a solution must then be renegotiated or a different coping mechanism adopted.

The capacity for effective problem solving is influenced by the person’s expectation of at least partial success. This prediction in turn depends on remembering past successes in similar situations. On this basis it is possible to go forward and deal with the current stressful situation.

Perseverance in problem solving also depends on the person’s expectation of a certain level of pain and discomfort and on belief in one’s being capable of tolerating the problem. Here lies the balance between courage and anxiety.

Critical Thinking: What coping mechanisms do you use when you are mildly, moderately, and severely anxious? How adaptive or maladaptive are they?

Emotion- or Ego-Focused Coping. Emotion- or ego-focused coping mechanisms are used often to protect the self. These reactions, also called defense mechanisms, are the first line of psychic defense. Everyone uses them, and they often help people cope successfully with mild and moderate levels of anxiety. Defense mechanisms protect the person from feelings of inadequacy and worthlessness and prevent awareness of anxiety. However, they can be used to such an extreme degree that they distort reality, interfere with interpersonal relationships, and limit the ability to work productively.

As coping mechanisms, they have certain drawbacks. First, ego defense mechanisms operate on unconscious levels. The person has little awareness of what is happening and little control over events. Secondly, they involve a degree of self-deception and reality distortion. Therefore they usually do not help the person cope with the problem realistically. Table 15-1 lists some of the more common ego defense mechanisms and examples of each.

The evaluation of whether the patient’s use of certain defense mechanisms is adaptive or maladaptive involves four issues:

1. The accurate recognition of the patient’s use of the defense mechanism by the nurse.
2. The degree to which the defense mechanism is used: Is there a high degree of personality disorganization? Is the person open to facts about the life situation?
3. The degree to which use of the defense mechanism interferes with the patient’s functioning.
4. The reason the patient used the ego defense mechanism.

The nurse will better understand the patient and plan more effective nursing care after considering these points.

Many coping mechanisms can be used to minimize anxiety. Some of them are essential for emotional stability. The exact nature and number of the defenses used strongly influence the personality pattern. When these defenses are overused or used unsuccessfully, they cause many physiological and psychological symptoms commonly associated with emotional illness.

Nursing Diagnoses

The nurse who has adequately assessed a patient and uses the Stuart Stress Adaptation Model can formulate a nursing diagnosis based on the patient’s position on the continuum of anxiety responses (Figure 15-4).

Initially the nurse needs to determine the quality and quantity of the anxiety experienced by the patient. Is the patient’s response to the perceived threat appropriate? Is it adaptive or irrational? A problem may exist if the response is out of proportion to the threat, indicating that the patient’s cognitive appraisal of the threat is unrealistic. Maladaptive responses are seen with severe and panic levels of anxiety.

The nurse also needs to explore how the patient is coping with the anxiety. Constructive coping mechanisms are protective responses that consciously confront the threat. Destructive coping mechanisms involve repression into the unconscious. They tend to be ineffective, inadequate, disorganized, inappropriate, and exaggerated. They may be evident in bizarre behavior or symptom formation.

Finally, the nurse needs to determine the overall effect of the anxiety. Is it stimulating growth? Or is it interfering with effective living and life satisfaction? Is it enhancing one’s sense of self? Or is it depersonalizing? Whenever possible, the patient should be included in identifying problem areas. This involvement may not always be feasible, however, particularly if the patient’s anxiety is at the severe or panic level.

The four primary NANDA International (NANDA-I) nursing diagnoses concerned with anxiety responses are anxiety, ineffective coping, readiness for enhanced coping, and fear. Many additional nursing problems may be identified from the way the patient’s anxiety reciprocally influences interpersonal relationships, self-concept, cognitive functioning, physiological status, and other aspects of life.

Nursing diagnoses related to the range of possible maladaptive responses and related medical diagnoses are identified in the Medical and Nursing Diagnoses box (Box 15-6). The primary NANDA-I nursing diagnoses and examples of expanded nursing
Table 15-1  Ego Defense Mechanisms

<table>
<thead>
<tr>
<th>Defense Mechanism</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensiation</td>
<td>A businessman perceives his small physical stature negatively. He tries to overcome this by being aggressive, forceful, and controlling in business dealings.</td>
</tr>
<tr>
<td>Denial</td>
<td>Mrs. P has just been told that her breast biopsy indicates a malignancy. When her husband visits her that evening, she tells him that no one has discussed the laboratory results with her.</td>
</tr>
<tr>
<td>Displacement</td>
<td>A 4-year-old boy is angry because he has just been punished by his mother for drawing on his bedroom walls. He begins to play war with his soldier toys and has them fight with each other.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>A man is brought to the emergency room by the police and is unable to explain who he is and where he lives or works.</td>
</tr>
<tr>
<td>Identification</td>
<td>A friend tells you that you are the most wonderful person in the world.</td>
</tr>
<tr>
<td>Intellectualization</td>
<td>Sally, 15 years old, has her hair styled like that of her young English teacher, whom she admires.</td>
</tr>
<tr>
<td>Introjection</td>
<td>A woman avoids dealing with her anxiety in shopping malls by explaining that shopping is a frivolous waste of time and money.</td>
</tr>
<tr>
<td>Rationalization</td>
<td>A medical student dissects a cadaver for her anatomy course without being disturbed by thoughts of death.</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>A young woman who denies she has sexual feelings about a co-worker accuses him without basis of trying to seduce her.</td>
</tr>
<tr>
<td>Regression</td>
<td>John fails an examination and complains that the lectures were not well organized or clearly presented.</td>
</tr>
<tr>
<td>Repression</td>
<td>A married woman who feels attracted to one of her husband’s friends treats him rudely.</td>
</tr>
<tr>
<td>Splitting</td>
<td>Four-year-old Nicole, who has been toilet trained for more than 1 year, begins to wet her pants again when her new baby brother is brought home from the hospital.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Mr. R does not recall hitting his wife when she is pregnant.</td>
</tr>
<tr>
<td>Suppression</td>
<td>A friend tells you that you are the most wonderful person in the world one day and how much she hates you the next day.</td>
</tr>
<tr>
<td>Undoing</td>
<td>A young man at work finds he is thinking so much about his date that evening that it is interfering with his work. He decides to put it out of his mind until he leaves the office for the day.</td>
</tr>
</tbody>
</table>

diagnoses are presented in the Detailed Diagnoses table (Table 15-2).

Medical Diagnoses

Many patients with mild or moderate anxiety have no medically diagnosed health problem. However, patients with more severe levels of anxiety usually have neurotic disorders that fall under the category of anxiety disorders in the DSM-IV-TR (American Psychiatric Association, 2000). These medical diagnoses include panic disorder with or without agoraphobia (Box 15-7), agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder (Box 15-8), posttraumatic stress disorder, acute stress disorder, and generalized anxiety disorder. The essential features of these medical diagnoses related to anxiety responses are presented in the Detailed Diagnoses table (see Table 15-2).

Neurosis describes a mental disorder characterized by anxiety that involves no distortion of reality. Neurotic disorders are
Unit Three  Applying Principles in Nursing Practice

CONTINUUM OF ANXIETY RESPONSES

Adaptive responses
Anticipation
Mild
Moderate

Maladaptive responses
Severe
Panic

PREDISPOSING FACTORS
Psychoanalytic  Interpersonal  Behavioral  Family  Biological

PRECIPITATING STRESSORS
Physical integrity  Self-system

APPRAISAL OF STRESSOR

COPING RESOURCES

COPING MECHANISMS
Task oriented  Ego oriented
Constructive
Destructive

Physical integrity          Self-system
Psychoanalytic     Interpersonal     Behavioral     Family     Biological

Mild Severe

Task oriented Ego oriented
Constructive
Destructive

Coping, Ineffective
Coping, Readiness for enhanced
Denial, Ineffective
Fear
Injury, Risk for
Memory, Impaired
Posttrauma syndrome
Powerlessness
Protection, Ineffective
Role performance, Ineffective
Self-esteem, Situational low
Sensory perception, Disturbed
Sleep pattern, Disturbed
Social interaction, Impaired
Thought processes, Disturbed
Tissue perfusion, Ineffective

Box 15-6 Medical and Nursing Diagnoses Related to Anxiety Responses

Related Medical Diagnoses (DSM-IV-TR)*
Panic disorder without agoraphobia
Panic disorder with agoraphobia
Agoraphobia without panic attacks
Specific phobia
Social phobia
Obsessive-compulsive disorder
Posttraumatic stress disorder
Acute stress disorder
Generalized anxiety disorder

Related Nursing Diagnoses (NANDA-I)†
Anxiety
Breathing pattern, Ineffective
Communication, Impaired verbal
Confusion, Acute

‡Primary nursing diagnosis for anxiety.
### Table 15-2  Detailed Diagnoses Related to Anxiety Responses

<table>
<thead>
<tr>
<th>NANDA-I Diagnosis Stem</th>
<th>Examples of Expanded Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Panic level of anxiety related to family rejection, as evidenced by confusion and impaired judgment.</td>
</tr>
<tr>
<td></td>
<td>Severe anxiety related to sexual conflict, as evidenced by repetitive hand washing and recurrent thoughts of dirt and germs.</td>
</tr>
<tr>
<td></td>
<td>Moderate anxiety related to marital conflict, as evidenced by inability to leave the house.</td>
</tr>
<tr>
<td></td>
<td>Moderate anxiety related to poor school performance, as evidenced by excessive use of denial and rationalization.</td>
</tr>
<tr>
<td></td>
<td>Moderate anxiety related to financial pressures, as evidenced by recurring episodes of abdominal pain and heartburn.</td>
</tr>
<tr>
<td></td>
<td>Moderate anxiety related to assumption of motherhood role, as evidenced by inhibition and avoidance.</td>
</tr>
<tr>
<td></td>
<td>Moderate anxiety related to poor school performance, as evidenced by excessive use of denial and rationalization.</td>
</tr>
<tr>
<td>Ineffective coping</td>
<td>Ineffective coping related to daughter's death, as evidenced by inability to recall events pertaining to the car accident.</td>
</tr>
<tr>
<td></td>
<td>Ineffective coping related to child's illness, as evidenced by limited ability to concentrate and psychomotor agitation.</td>
</tr>
<tr>
<td>Readiness for enhanced coping</td>
<td>Readiness for enhanced coping related to adoption of grandchild because of death of the child's parents, as evidenced by engagement in family therapy and modification of living environment to promote the inclusion of a child in the home.</td>
</tr>
<tr>
<td>Fear</td>
<td>Fear related to impending surgery, as evidenced by generalized hostility toward staff and restlessness.</td>
</tr>
</tbody>
</table>

### DSM-IV-TR Diagnosis

<table>
<thead>
<tr>
<th>Essential Features*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panic disorder without agoraphobia</strong></td>
</tr>
<tr>
<td>Recurrent unexpected panic attacks (Box 15-7), with at least one of the attacks followed by 1 month (or more) of persistent concern about having additional attacks, worry about the implications of the attack or its consequences, or a significant change in behavior related to the attacks. Also the absence of agoraphobia.</td>
</tr>
<tr>
<td><strong>Panic disorder with agoraphobia</strong></td>
</tr>
<tr>
<td>Meets the above criteria. In addition, includes the presence of agoraphobia, which is anxiety about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available in the event of a panic attack. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or car. Agoraphobic situations are avoided, or endured with marked distress or with anxiety about having a panic attack, or require the presence of a companion.</td>
</tr>
<tr>
<td><strong>Agoraphobia without history of panic disorder</strong></td>
</tr>
<tr>
<td>The presence of agoraphobia without meeting criteria for panic disorder.</td>
</tr>
<tr>
<td><strong>Specific phobia</strong></td>
</tr>
<tr>
<td>Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, or seeing blood). Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response. The person recognizes the fear is excessive, and the distress or avoidance interferes with the person's normal routine.</td>
</tr>
<tr>
<td><strong>Social phobia</strong></td>
</tr>
<tr>
<td>A marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person fears acting in a way (or showing anxiety symptoms) that will be humiliating or embarrassing. Exposure to the feared situation almost invariably provokes anxiety. The person recognizes the fear is excessive, and the distress or avoidance interferes with the person's normal routine.</td>
</tr>
<tr>
<td><strong>Obsessive-compulsive disorder</strong></td>
</tr>
<tr>
<td>Either obsessions or compulsions (Box 15-8) are recognized as excessive and interfere with the person's normal routine.</td>
</tr>
<tr>
<td><strong>Posttraumatic stress disorder</strong></td>
</tr>
<tr>
<td>The person has been exposed to a traumatic event in which both of the following were present: The person has experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity of oneself or others. The person's response involved intense fear, helplessness, or horror. The traumatic event is reexperienced in the mind, and there is an avoidance of stimuli associated with the trauma and a numbing of general responsiveness.</td>
</tr>
<tr>
<td><strong>Acute stress disorder</strong></td>
</tr>
<tr>
<td>Meets the criteria for exposure to a traumatic event and person experiences three of the following symptoms: sense of detachment, reduced awareness of one's surroundings, derealization, depersonalization, and dissociated amnesia.</td>
</tr>
<tr>
<td><strong>Generalized anxiety disorder</strong></td>
</tr>
<tr>
<td>Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities. The person finds it difficult to control the worry and experiences at least three of the following symptoms: restlessness or feeling keyed up or on edge, fatigue, difficulty concentratitng or mind going blank, irritability, muscle tension, sleep disturbance.</td>
</tr>
</tbody>
</table>

Box 15-7 Panic Attack Criteria

A panic attack is a discrete period of intense fear or discomfort in which at least four of the following symptoms develop abruptly and reach a peak within 10 minutes:

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


Box 15-8 Obsession and Compulsion Criteria

Obsession

Recurrent and persistent thoughts, impulses, or images are experienced during the disturbance as intrusive and inappropriate and cause marked anxiety or distress. The thoughts, impulses, or images are not simply excessive worries about real-life problems. The person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action. The person recognizes that the obsessional thoughts, impulses, or images are a product of one’s own mind.

Examples

Fear of dirt and germs
Fear of burglary or robbery
Worries about discarding something important
Concerns about contracting a serious illness
Worries that things must be symmetrical or matching

Compulsion

The person feels driven to perform repetitive behaviors or mental acts in response to an obsession or according to rules that one deems must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

Examples

Excessive hand washing
Repeated checking of door and window locks
Counting and recounting of objects in everyday life
Hoarding of objects
Excessive straightening, ordering, or arranging of things
Repeating words or prayers silently


Goals such as “decrease anxiety” and “minimize anxiety” lack specific behaviors and evaluation criteria. Therefore these goals are not particularly useful in guiding nursing care and evaluating its effectiveness. The expected outcome for patients with maladaptive anxiety responses is as follows: The patient will demonstrate adaptive ways of coping with stress.

Short-term goals can break this expected outcome down into readily attainable steps. This identification of steps allows the patient and nurse to see progress even if the ultimate goal still appears distant.

If the patient’s anxiety is at the severe or panic level, the highest-priority short-term goals should address safety and lowering the anxiety level. Only after this decreased anxiety has been achieved can additional progress be made. The reduced level of anxiety should be evident in a reduction of behaviors associated with severe or panic levels.
When these goals are met, the nurse can assume that the patient's level of anxiety has been reduced. The nurse may then develop new short-term goals directed toward insight or relaxation therapy. In addition, since anxiety is a subjective response, a useful measure would be to ask the patient to rate the level of anxiety from 1 to 10. Obtaining a rating of 2 or 3 might be another expected outcome.

Outcome indicators related to anxiety self-control from the Nursing Outcome Classification (NOC) project are presented in Box 15-9 (Moorhead et al, 2008).

◆ PLANNING

The main goal of the nurse working with anxious patients is not to free them totally from anxiety. Patients need to develop the capacity to tolerate mild anxiety and to use it consciously and constructively. In this way the self will become stronger and more integrated. As patients learn from these experiences, they will move on in their development.

Anxiety can be considered a war between the threat and the values people identify with their existence. Maladaptive behavior means that the struggle has been lost. The constructive approach to anxiety means that the struggle is won by the person's values. Thus a general nursing goal is to help patients develop sound values. This approach does not mean that patients assume the nurse's values. Rather, the nurse helps patients sort out their own values.

Anxiety also can be an important factor in the patient’s decision to seek treatment. Because anxiety is undesirable, the patient will seek ways to reduce it. If the patient's coping mechanism or symptom does not minimize anxiety, the motivation for treatment increases. Conversely, anxiety about the therapeutic process can delay or prevent the person from seeking treatment.

The patient should actively participate in planning treatment strategies. If the patient is actively involved in identifying relevant stressors and planning possible solutions, the success of the implementation phase will be maximized. A patient in extreme anxiety initially will not be able to participate in the problem-solving process. However, as soon as anxiety is reduced, the nurse should encourage patient involvement. This participation reinforces that patients are responsible for their own growth and personal development.

◆ IMPLEMENTATION

Practice guidelines have been developed to treat a variety of anxiety disorders (American Psychiatric Association, 1998, 2004, 2007).

### Table 15-3 Differences Between Anxiety and Depression

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Depression</th>
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</thead>
<tbody>
<tr>
<td>Predominantly fear or apprehension</td>
<td>Predominantly sad or hopeless with feelings of despair</td>
</tr>
<tr>
<td>Difficulty falling asleep (initial insomnia)</td>
<td>Early-morning awakening (late insomnia) or hypersomnia</td>
</tr>
<tr>
<td>Phobic avoidance behavior</td>
<td>Diurnal variation (feels worse in the morning)</td>
</tr>
<tr>
<td>Rapid pulse and psychomotor hyperactivity</td>
<td>Slowed speech and thought processes</td>
</tr>
<tr>
<td>Breathing disturbances</td>
<td>Psychomotor retardation (agitation also may occur)</td>
</tr>
<tr>
<td>Tremors and palpitations</td>
<td>Delayed response time</td>
</tr>
<tr>
<td>Sweating and hot or cold spells</td>
<td></td>
</tr>
<tr>
<td>Faintness, lightheadedness, dizziness</td>
<td></td>
</tr>
<tr>
<td>Depersonalization (feeling detached from one's body)</td>
<td></td>
</tr>
<tr>
<td>Derealization (feeling that one's environment is strange, unreal, or unfamiliar)</td>
<td></td>
</tr>
<tr>
<td>Selective and specific negative appraisals that do not include all areas of life</td>
<td></td>
</tr>
<tr>
<td>Sees some prospects for the future</td>
<td></td>
</tr>
<tr>
<td>Does not regard defects or mistakes as irrevocable</td>
<td>Inability to experience pleasure</td>
</tr>
<tr>
<td>Uncertain in negative evaluations</td>
<td>Loss of interest in usual activities</td>
</tr>
<tr>
<td>Predicts that only certain events may go badly</td>
<td>Negative appraisals are pervasive, global, and exclusive</td>
</tr>
<tr>
<td></td>
<td>Thoughts of death or suicide</td>
</tr>
<tr>
<td></td>
<td>Sees the future as blank and has given up all hope</td>
</tr>
<tr>
<td></td>
<td>Regards mistakes as beyond redemption</td>
</tr>
<tr>
<td></td>
<td>Absolute in negative evaluations</td>
</tr>
<tr>
<td></td>
<td>Global view that nothing will turn out right</td>
</tr>
</tbody>
</table>

Box 15-9 NOC Outcome Indicators for Anxiety Self-Control

| Monitors intensity of anxiety |
| Eliminates precursors of anxiety |
| Decreases environmental stimuli when anxious |
| Seeks information to reduce anxiety |
| Plans coping strategies for stressful situations |
| Uses effective coping strategies |
| Uses relaxation techniques to reduce anxiety |
| Monitors duration of episodes |
| Monitors length of time between episodes |
| Maintains role performance |
| Maintains social relationships |
| Maintains concentration |
| Monitors sensory perceptual distortions |
| Maintains adequate sleep |
| Monitors physical manifestations of anxiety |
| Monitors behavioral manifestations of anxiety |
| Controls anxiety response |

Cognitive behavioral therapy involving exposure and ritual prevention is well-established treatment for OCD in adults.

The most successful psychological treatments for GAD combine relaxation, exercise, and cognitive therapy with the goal of bringing the worry process under the patient's control. The pharmacological treatments of choice are buspirone and antidepressants, including SSRIs and venlafaxine.

Obese-compulsive disorder (OCD) 
Cognitive behavioral therapy involving exposure and ritual prevention is well-established treatment for OCD in adults. The serotonin reuptake inhibitors (SRIs) have been shown repeatedly to be efficacious in the treatment of OCD. Behavior therapy and perhaps cognitive therapy may be superior to medication with respect to risks, costs, and enduring benefit.

Panic disorder (PD) with or without agoraphobia 
Situational in vivo exposure has been shown to be effective for patients with PD with moderate to severe agoraphobia. Cognitive behavioral treatments are effective for persons with panic disorder with no more than mild agoraphobia. These treatments focus on cognitive therapy, exposure to interoceptive sensations similar to physiological panic sensations, and breathing. SSRIs are now considered to be the first-line pharmacological treatment for PD, affecting panic frequency, generalized anxiety, disability, and phobic avoidance.

Posttraumatic stress disorder (PTSD) 
The SSRS are efficacious in reducing PTSD-specific symptoms and improving global outcome. Tricyclic antidepressants and MAOIs have also been found to be efficacious. Several past- and present-focused psychosocial treatments are effective. Past-focused treatments emphasize repeated exposure to the memories and emotions of the event in order to diminish their impact. Present-focused treatments teach coping skills to improve functioning.

Social phobia 
The most common treatment approaches to social phobia include social skills training, relaxation techniques, exposure-based methods, and multicomponent cognitive behavioral treatments, with the latter two attaining the highest levels of treatment efficacy. SSRIs are an attractive first-line treatment for social phobia.

Specific phobias 
The treatment of choice for specific phobias is exposure-based procedures, particularly in vivo exposure. In general, pharmacological treatments have not proved effective for specific phobias.

Empirically validated treatments for some of the medical diagnoses related to anxiety disorders are summarized in Table 15-4 (Nathan and Gorman, 2007).

### Severe and Panic Levels of Anxiety

**Establishing a Trusting Relationship.** To reduce the patient's level of anxiety, most nursing actions are purposely protective and supportive. Initially nurses need to establish an open, trusting relationship. Nurses should actively listen to patients and encourage them to discuss their feelings of anxiety, hostility, guilt, and frustration. Nurses should answer patients' questions directly and offer unconditional acceptance. Their verbal and nonverbal communications should convey awareness and acceptance of patients' feelings.

Nurses should remain available and respect the patient's personal space. A 6-foot distance in a small room may create the optimum condition for openness and discussion of fears. The more this distance is increased or decreased, the more anxious the patient may become.

**Nurses' Self-Awareness.** Nurses’ feelings are particularly important in working with highly anxious patients. They may find themselves being unsympathetic, impatient, and frustrated. These are common feelings of reciprocal anxiety. If nurses are alert to the development of anxiety in themselves, they can learn from it and use it therapeutically. Nurses should be alert to the signs of anxiety in themselves, accept them, and attempt to explore their cause. The nurse may ask the following questions:

- What is threatening me?
- Have I failed to live up to what I imagine to be the patient's ideal?
- Am I comparing myself with a peer or another health professional?
- Is the patient's area of conflict one that I have not resolved in myself?
- Is my anxiety related to something that will or may happen in the future?
- Is my patient's conflict really one of my own that I am projecting?

If nurses deny their own anxiety, it can have detrimental effects on the nurse-patient relationship. Because of their own anxiety, nurses may be unable to differentiate among levels of anxiety in others. They also may transfer their fears and frustrations to patients, thus compounding their problems.

Nurses who are anxious arouse defenses in patients and other staff members that interfere with their therapeutic usefulness. **Nurses should strive to accept their patients' anxiety without reciprocal anxiety by continually clarifying their**
own feelings and role. This is seen in the following clinical example.

❖ **CLINICAL EXAMPLE** Ms. R was a 35-year-old married woman and mother of three children, ages 4, 6, and 9 years. She was a full-time homemaker and mother. Her husband was a salesperson and spent about 2 nights each week out of town. She came to the clinic complaining of severe headaches that "come on me very suddenly and are so terrible that I have to go to bed. The only thing that helps is for me to lie down in a dark and absolutely quiet room." She said that these headaches were becoming a real problem for everyone in the family, and her husband told her that she "just had to get over them and get things back to normal."

Mr. W, a psychiatric nurse, offered to see Ms. R in therapy weekly. After 3 weeks he was asked to present his evaluation, treatment plan, and progress report to the clinic staff at their weekly team conference. Mr. W began his presentation by stating, "This case is really tough. I'll start with the progress report and say that there is none because I can't seem to get past all the complaining this patient does!" He then went on to discuss his evaluation and treatment plan in depth. It became obvious to the other members of the staff that Mr. W saw his patient as a woman who was not living up to her roles and responsibilities. He defended Ms. R's husband even though the husband refused to come to the sessions with his wife. When one of the team members asked about the possibility of a medication evaluation for Ms. R, the nurse replied, "Everyone gets headaches. I don't think we should reward or reinforce this woman's complaints."

In reviewing this case the staff noted that Mr. W appeared to have problems relating empathetically to his patient because of the severe and chronic nature of her symptoms, some of her own values and perceptions. Mr. W agreed with this and said he had thought of asking someone else to work with Ms. R. Mr. W's supervisor observed that the nurse had problems with this type of patient in the past, and a more constructive approach would be to increase his supervision on this case, focusing on the dynamics between the patient and nurse that were blocking learning and growth for both of them. Mr. W and his supervisor set a time when they could begin to meet for this purpose.❖

❖ **Critical Thinking** What clinical situations or patient problems raise your level of anxiety?

### Protecting the Patient

**A major area of intervention is protecting patients and assuring patients of their safety.** One way to decrease anxiety is by allowing patients to determine the amount of stress they can handle at the time. Nurses should not force severely anxious patients into situations they are not able to handle. Neither should they attack patients' coping mechanisms. Rather, nurses should attempt to protect patients' defenses.

The coping mechanism or symptom is attempting to deal with an unconscious conflict. Usually patients do not understand why the symptom has developed or what they are gaining from it. They know only that the symptom relieves some of the intolerable anxiety and tension. Thus asking "why" questions of patients related to their behaviors or symptoms is not helpful.

If patients are unable to release this anxiety, their tension mounts to the panic level, and they could lose control. It also is important to remember that the severely anxious patient has not worked through the area of conflict and therefore has no alternatives or substitutes for present coping mechanisms. This principle applies to severe levels of anxiety, such as seen in obsessive-compulsive reactions, phobias, and panic attacks. Nurses should not initially interfere with a patient's repetitive act or force patients to confront the avoided situation or phobic object. They should not ridicule the nature of the defense. Also, nurses should not attempt to argue with patients about it or reason them out of it. Patients need their coping mechanisms to keep anxiety within tolerable limits.

Neither should nurses reinforce the phobia, ritual, avoidance, or physical complaint by focusing attention on it and talking about it a great deal. With time, however, nurses can place some limits on patients' behavior and attempt to help them find satisfaction with other aspects of life.

Some nursing interventions can increase anxiety in severely anxious patients. These include pressuring the patient to change prematurely, being judgmental, verbally disapproving of the patient's behaviors, and asking the patient a direct question that brings on defensiveness. Focusing in a critical way on the patient's anxious feelings with others present, lacking awareness of one's own behaviors and feelings, and withdrawing from the patient also can be harmful.

### Modifying the Environment

The nurse can consult with others to identify anxiety-producing situations and attempt to reduce them. The nurse can set limits by assuming a quiet, calm manner and decreasing environmental stimulation. Supportive physical measures such as warm baths, massages, or whirlpool baths also may be helpful in decreasing a patient's anxiety.

### Encouraging Activity

**The nurse needs to encourage the patient's interest in activities.** This involvement limits the time available for destructive coping mechanisms and increases participation in and enjoyment of other aspects of life. The nurse might suggest physical activities, such as walking, a sport, or an active hobby. This form of physical exercise helps to relieve anxiety because it provides an emotional release and directs the patient's attention outward. Family members should be involved in the planning because they can be very supportive in setting limits and stimulating outside activity (Box 15-10).

### Medication

**Medications** are very effective in treating anxiety disorders (Table 15-5). The goals of pharmacological treatment are to do the following:

- Reduce core symptoms.
- Improve functioning.
- Strengthen resilience.
- Relieve comorbid symptoms.
- Prevent relapse.

Benzodiazepines are effective in the treatment of anxiety disorders. However, use of benzodiazepines in combination with alcohol may result in a serious or even fatal sedative reaction. Other potential dangers of benzodiazepines include withdrawal syndrome side effects and addiction. **Antidepressants** also are used in the treatment of anxiety disorders because of their effectiveness and low side effect profile. More detailed information on medications is presented in Chapter 26.

Although some patients may need to take antianxiety drugs for extended periods, these drugs should always be used together with psychosocial treatments. Medication is not a substitute for an ongoing therapeutic relationship, but it can enhance the
therapeutic alliance. Chemical control of painful symptoms allows the patient to direct attention to the conflicts underlying the anxiety.

The Nursing Treatment Plan Summary (Table 15-6) reviews interventions related to severe and panic levels of anxiety.

Moderate Level of Anxiety

The nursing interventions previously mentioned are supportive and directed toward the short-term goal of reducing severe- or panic-level anxiety. When the patient’s anxiety is reduced to a moderate level, the nurse can begin helping with problem-solving efforts to cope with the stress.

Long-term goals now focus on helping the patient understand the cause of the anxiety and learn new ways of controlling it. Goals include gaining recognition of and insight into the anxiety and learning new, adaptive coping behaviors. They incorporate principles and techniques of cognitive behavioral therapy (Chapter 29) and can be implemented in any setting: psychiatric, community, home, or general hospital.

Psychoeducation. Education is important in promoting the patient’s adaptive responses to anxiety. The nurse can identify the health teaching needs of each patient and then formulate a plan to meet those needs (Moller and Rice, 2006; Phoenix, 2007).

Plans should be designed to increase patients’ knowledge of their own predisposing and precipitating stressors, coping resources, and adaptive and maladaptive responses. Alternative coping strategies can be identified and explored. Health teaching also should address the beneficial aspects of mild levels of anxiety in motivating learning and producing growth and creativity.

Although further research is needed to clarify the mechanisms that cause anxiety disorders, the clinical significance of current findings can be reassuring to patients. Patients can be told, for example, that anxiety disorders are a dysregulation in the normal fight-or-flight response, which is important to survival.

<table>
<thead>
<tr>
<th>Table 15-5 Antianxiety Drugs</th>
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<tbody>
<tr>
<td><strong>Generic Name (Trade Name)</strong></td>
</tr>
<tr>
<td><strong>Antianxiety Drugs</strong></td>
</tr>
<tr>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
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<tr>
<td>Chlordiazepoxide (Librium)</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
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<tr>
<td>Clorazepate (Tranxene)</td>
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<tr>
<td>Diazepam (Valium)</td>
</tr>
<tr>
<td>Halazepam (Paxipam)</td>
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<tr>
<td>Lorazepam (Ativan)</td>
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<tr>
<td>Oxazepam (Serax)</td>
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<tr>
<td><strong>Antihistamines</strong></td>
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<tr>
<td>Diphenhydramine (Benadryl)</td>
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<tr>
<td>Hydroxyzine (Atarax, Vistaril)</td>
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<tr>
<td><strong>Nonadrenergic Agents</strong></td>
</tr>
<tr>
<td>Clonidine (Catapres)</td>
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<tr>
<td>Propranolol (Inderal)</td>
</tr>
<tr>
<td><strong>Anxiolytic</strong></td>
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<tr>
<td>Buspirone (BuSpar)</td>
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<tr>
<td><strong>Antidepressant/Antianxiety Drugs</strong></td>
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<tr>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
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<tr>
<td>Escitalopram (Lexapro)</td>
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<tr>
<td>Fluoxetine (Prozac)</td>
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<td>Fluvoxamine (Lavox)</td>
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<tr>
<td>Paroxetine (Paxil)</td>
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<tr>
<td>Sertraline (Zoloft)</td>
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<tr>
<td>Other Newer Antidepressants</td>
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<tr>
<td>Amoxapine (Asendin)</td>
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<tr>
<td>Buproprion (Wellbutrin)</td>
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<tr>
<td>Duloxetine (Cymbalta)</td>
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<td>Maprotiline (Ludomil)</td>
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<td>Mirtazapine (Remeron)</td>
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<td>Nefazodone (Serzone)</td>
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<tr>
<td>Trazodone (Desyrel)</td>
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<tr>
<td>Venlafaxine (Effexor)</td>
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<tr>
<td><strong>Tricyclics</strong></td>
</tr>
<tr>
<td>Amitriptyline (Elavil)</td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
</tr>
<tr>
<td>Doxepin (Sinequan)</td>
</tr>
<tr>
<td>Imipramine (Tofranil)</td>
</tr>
<tr>
<td>Nortriptyline (Pamelor)</td>
</tr>
<tr>
<td>Protriptyline (Vivactil)</td>
</tr>
<tr>
<td>Trimipramine (Surmontil)</td>
</tr>
<tr>
<td><strong>Monoamine Oxidase Inhibitors (MAOIs)</strong></td>
</tr>
<tr>
<td>Isocarboxazid (Marplan)</td>
</tr>
<tr>
<td>Phenelzine (Nardil)</td>
</tr>
<tr>
<td>Selegiline (Eldepryl)</td>
</tr>
<tr>
<td>Selegiline (Emsam)</td>
</tr>
<tr>
<td>Tranylcypromine (Parnate)</td>
</tr>
</tbody>
</table>

*Antidepressants with a ceiling dose because of dose-related seizures.
The way in which anxiety disorders present may be a combination of genetic vulnerability and a person’s reactions to life’s stressors. Most importantly, patients should be told that anxiety disorders can be successfully treated by a variety of evidence-based treatments. This information can give patients a sense of control over anxiety’s seemingly uncontrollable and debilitating effects.

**Recognition of Anxiety.** After analyzing the patient’s behaviors and determining the level of anxiety, the nurse helps the patient recognize anxiety by exploring underlying feelings with questions such as “Are you feeling anxious now?” or “Are you uncomfortable?”

It is helpful for the nurse to identify the patient’s behavior and link it to the feeling of anxiety (e.g., “I noticed you have been tapping your foot since we started talking about your sister. Are you feeling anxious?”). In this way the nurse acknowledges the patient’s feeling, attempts to label it, encourages the patient to describe it further, and relates it to a specific behavioral pattern. The nurse is also validating inferences and assumptions with the patient.

However, the patient’s goal is often to avoid or deny anxiety, and the patient may use any of the resistive approaches described in Box 15-11. All these approaches may create feelings of frustration, irritation, or reciprocal anxiety in the nurse, who must recognize personal feelings and identify the patient’s behavior pattern that might be causing them.

At this time a trusting relationship is very important. Nurses who establish themselves as warm, responsive listeners, give patients adequate time to respond, and support the patient’s self-expression will become less threatening.

In helping patients recognize their anxiety, nurses should use open questions that move from nonthreatening topics to central issues of conflict. In time, supportive confrontation may be used...

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**Table 15-6 Nursing Treatment Plan Summary Severe and Panic Anxiety Responses**

<table>
<thead>
<tr>
<th>Nursing Diagnosis: Severe/panic level anxiety</th>
<th>Expected Outcome: The patient will reduce anxiety to a moderate or mild level.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Goal</strong></td>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>The patient will be protected from harm.</td>
<td>Initially accept and support, rather than attack, the patient’s defenses. Do not ask the patient why the symptoms exist. Acknowledge the reality of the pain associated with the patient’s present coping mechanisms. Do not focus on the phobia, ritual, or physical complaint itself. Give feedback to the patient about behavior, stressors, appraisal of stressors, and coping resources. Reinforce the idea that physical health is related to emotional health and that this is an area that will need exploration. In time, begin to place limits on the patient’s maladaptive behavior in a supportive way.</td>
</tr>
<tr>
<td>The patient will experience fewer anxiety-provoking situations.</td>
<td>Assume a calm manner with the patient. Decrease environmental stimulation. Limit the patient’s interaction with other patients to minimize the contagious aspects of anxiety. Identify and modify anxiety-provoking situations for the patient. Administer supportive physical measures, such as warm baths and massages.</td>
</tr>
<tr>
<td>The patient will engage in a daily schedule of activities.</td>
<td>Initially share an activity with the patient to provide support and reinforce socially productive behavior. Provide for physical exercise of some type. Plan a schedule or list of activities that can be carried out daily. Involve family members and other support systems as much as possible.</td>
</tr>
<tr>
<td>The patient will experience relief from the symptoms of severe anxiety.</td>
<td>Administer medications that help reduce the patient’s discomfort. Observe for medication side effects, and initiate relevant health teaching.</td>
</tr>
</tbody>
</table>
to address a particularly resistive pattern. However, if the patient’s level of anxiety begins to rise rapidly, the nurse might choose to refocus the discussion to another topic.

**Insight into the Anxiety.** Once the patient is able to recognize anxiety, the nurse can help the patient gain insight by asking the patient to describe the situations, interactions, and thoughts that immediately precede the increase in anxiety. Together the nurse and patient make inferences about the precipitating causes or biopsychosocial stressors.

The nurse then helps the patient see which values are being threatened by linking the threat with underlying causes, analyzing how the conflict developed, and relating the patient’s present experiences to past ones. It is also important to explore how the patient reduced anxiety in the past and what kinds of actions produced relief.

**Coping with the Threat.** If previous coping responses have been adaptive and constructive, the patient should be encouraged to use them. If not, the nurse can point out their maladaptive effects and help the patient see that the present way of life appears unsatisfactory and distressing. The patient needs to assume responsibility for actions and realize that limitations have been self-imposed. Other people must not be blamed.

In this phase of intervention the nurse assumes an active role by interpreting, analyzing, confronting, and correlating cause-and-effect relationships. The nurse should proceed clearly so that the patient can follow while keeping anxiety within appropriate limits (Langeland et al, 2007).

The nurse can help the patient in problem-solving efforts using a variety of cognitive and behavioral strategies. Specifically, cognitive behavioral therapy has been shown to be most effective in treating anxiety disorders (Bradley et al, 2005; Bisson et al, 2007b; Wheeler, 2007; Bjorgvinsson et al, 2007; Rhoads et al, 2007). These treatments include a number of therapeutic strategies, which can be divided into three groups:

1. **Anxiety reduction**
2. **Cognitive restructuring**
3. **Learning new behavior**

The specific strategies for each group are listed in Box 15-12. They are explained in detail in Chapter 29.

One way of helping the patient cope is to reevaluate the nature of the threat or stressor. Is it as bad as the patient perceives it? Is the cognitive appraisal realistic? Together the nurse and patient might discuss fears and feelings of inadequacy.

Does the patient fear that others are as critical, perfectionistic, and rejecting as the patient is of others? Is the conflict based in reality, or is it the result of unvalidated, isolated, and distorted thinking? By sharing fears with family members, peers, and staff, the patient often gains insight into such misperceptions.

Another approach is to help the patient modify behavior and learn new ways of coping with stress. The nurse may act as a role

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**Box 15-11 Patient Resistances to Recognizing Anxiety**

- **Screen symptoms.** The patient focuses attention on minor physical ailments to avoid acknowledging anxiety and conflict areas.
- **Superior status position.** The patient attempts to control the interview by questioning the nurse’s abilities or asserting the superiority of the patient’s knowledge or experiences. The nurse should not respond emotionally to this approach or accept the patient’s challenge and compete because this would only further avoid the issue of anxiety.
- **Emotional seduction.** The patient attempts to manipulate the nurse and elicit pity or sympathy.
- **Superficiality.** The patient relates on a surface level and resists the nurse’s attempts to explore underlying feelings or analyze issues.
- **Circumlocution.** The patient gives the pretense of answering questions but actually talks around the topic to avoid it.
- **Amnesia.** This is a type of purposeful forgetting of an incident to avoid confronting and exploring it with the nurse.
- **Denial.** The patient may use this approach only when discussing significant issues with the nurse or may generalize denial to all others, including self. The purpose is often to avoid humiliation.
- **Intellectualization.** Patients who use this technique usually have some knowledge of psychology or medicine. They are able to express appropriate insights and analysis yet lack personal involvement in the problem they describe. They are not actually participating in the problem-solving process.
- **Hostility.** The patient believes that offense is the best defense and therefore relates to others in an aggressive, defiant manner. The greatest danger in this situation is that the nurse will take this behavior personally and respond with anger. This reinforces the patient’s avoidance of anxiety.
- **Withdrawal.** The patient may resist the nurse by replying in vague, diffuse, indefinite, and remote ways.

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**Box 15-12 Cognitive Behavioral Treatment Strategies for Anxiety Disorders**

- **Anxiety reduction**
  - Relaxation training
  - Biofeedback
  - Systematic desensitization
  - Interoceptive exposure
  - Flooding
  - Vestibular desensitization training
  - Response prevention
  - Eye movement desensitization and reprocessing (EMDR)

- **Cognitive Restructuring**
  - Monitoring thoughts and feelings
  - Questioning the evidence
  - Examining alternatives
  - “Decatastrophizing”
  - Reframing
  - Thought stopping

- **Learning New Behavior**
  - Modeling
  - Shaping
  - Token economy
  - Role playing
  - Social skills training
  - Aversion therapy
  - Contingency contracting
Describe the characteristics and benefits of relaxation.

Teach deep muscle relaxation through a sequence of tension-relaxation exercises.

Discuss the relaxation procedure of meditation and its components.

Help patient overcome anxiety-provoking situations through systematic desensitization.

Allow the rehearsing and practical use of relaxation in a safe environment.

Encourage patient to use relaxation techniques in life.

Discuss physiological changes associated with relaxation, and contrast these with the behaviors of anxiety.

Engage the patient in the progressive procedure of tensing and relaxing voluntary muscles until the body as a whole is relaxed.

Describe the elements of meditation, and help the patient use this technique.

With patient, construct a hierarchy of anxiety-provoking situations or scenes. Through imagination or reality, work through these scenes using relaxation techniques.

Role play stressful situations with the nurse or other patients.

Assign homework of using the relaxation response in everyday experiences.

Patient identifies own responses to anxiety. Patient describes elements of a relaxed state.

Patient is able to tense and relax all muscle groups. Patient identifies muscles that become particularly tense.

Patient selects a word or scene with pleasant connotations and engages in relaxed meditation. Patient identifies and ranks anxiety-provoking situations.

Patient exposes self to these situations while remaining in a relaxed state.

Patient becomes more comfortable with new behavior in a safe, supportive setting. Support success of patient.

Patient uses relaxation response in life situations. Patient is able to regulate anxiety response through use of relaxation techniques.

model or engage the patient in role playing. This activity can decrease anxiety about new responses to problem situations.

Another nursing intervention is to teach the patient how aspects of mild anxiety can be constructive and produce growth. Physical activity should be encouraged as a way to discharge anxiety. Interpersonal resources such as family members or close friends should be incorporated into the nursing plan of care to provide the patient with support.

Often the cause for anxiety arises from an interpersonal conflict. In this case it is constructive to include the people involved when analyzing the situation with the patient. In this way, cause-and-effect relationships are more open to examination. Coping patterns can be examined in light of their effect on others, as well as on the patient.

Working through this problem-solving or reeducative process with the patient takes time because it has to be accepted both intellectually and emotionally. Breaking previous behavioral patterns can be difficult. Nurses need to be patient and consistent and continually reappraise their own anxiety.

**Promoting the Relaxation Response.** In addition to problem solving, one also can cope with stress by regulating the emotional distress associated with it. Long-term goals directed toward helping the patient regulate emotional distress include promoting the relaxation response.

Relaxation can be taught individually, in small groups, or in large-group settings. A Patient Education Plan for teaching the relaxation response is presented in Table 15-7. It is within the scope of nursing practice, requires no special equipment, and does not need a physician's supervision.

As a group of interventions, relaxation can be implemented in various settings. A major benefit for patients is that after several training sessions, they can practice the techniques on their own.

This puts the control in their hands and increases their self-reliance. Relaxation training is described in detail in Chapter 29. A Nursing Treatment Plan Summary for patients with moderate anxiety is presented in Table 15-8.

**EVALUATION**

Even before beginning to formulate the nursing diagnosis, the nurse should ask, “Did I accurately observe my patient’s behaviors? Did I listen to my patient’s subjective description of anxiety? Did I fail to see the relationships between my patient’s expressed hostility or guilt and underlying anxiety? Did I assess intellectual and social functioning?”

After collecting the data, the nurse should analyze them: “Was I able to identify the precipitating stressor for the patient? What was the patient’s perception of the threat? How was this influenced by physical health, past experiences, and present feelings and needs? Did I correctly identify the patient’s level of anxiety and validate it?”

When using the criteria of adequacy, effectiveness, appropriateness, efficiency, and flexibility in evaluating the nursing goals and actions, the following questions can be raised:

- Were the planning, implementation, and evaluation mutual?
- Were goals and actions adequate in number and specific enough to minimize the patient’s level of anxiety?
- Were maladaptive responses reduced?
- Were new adaptive coping responses learned?
- Was the nurse accepting of the patient and able to monitor personal anxiety throughout the relationship?

The nurse also will identify personal strengths and limitations in working with the anxious patient. Plans may then be made for overcoming the areas of limitation and further improving nursing care.
Table 15-8 Nursing Treatment Plan Summary Moderate Anxiety Responses

<table>
<thead>
<tr>
<th>Nursing Diagnosis: Moderate level of anxiety</th>
<th>Expected Outcome: The patient will demonstrate adaptive ways of coping with stress.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Goal</strong></td>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>The patient will identify and describe</td>
<td>Help the patient identify and describe underlying feelings.</td>
</tr>
<tr>
<td>feelings of anxiety.</td>
<td>Link the patient’s behavior with such feelings.</td>
</tr>
<tr>
<td></td>
<td>Validate all inferences and assumptions with the patient.</td>
</tr>
<tr>
<td></td>
<td>Use open questions to move from nonthreatening topics to issues of conflict.</td>
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<tr>
<td></td>
<td>In time, supportive confrontation may be used judiciously.</td>
</tr>
<tr>
<td>The patient will identify antecedents of</td>
<td>Help the patient describe the situations and interactions that immediately precede anxiety.</td>
</tr>
<tr>
<td>anxiety.</td>
<td>Review the patient’s appraisal of the stressor, values being threatened, and the way in which the conflict developed.</td>
</tr>
<tr>
<td></td>
<td>Relate the patient’s present experiences with relevant ones from the past.</td>
</tr>
<tr>
<td>The patient will describe adaptive and</td>
<td>Explore how the patient reduced anxiety in the past and what kinds of actions produced relief.</td>
</tr>
<tr>
<td>maladaptive coping responses.</td>
<td>Point out the maladaptive and destructive effects of present coping responses.</td>
</tr>
<tr>
<td></td>
<td>Encourage the patient to use adaptive coping responses that were effective in the past.</td>
</tr>
<tr>
<td></td>
<td>Focus responsibility for change on the patient.</td>
</tr>
<tr>
<td></td>
<td>Actively help the patient correlate cause-and-effect relationships while maintaining anxiety within appropriate limits.</td>
</tr>
<tr>
<td></td>
<td>Help the patient reappraise the value, nature, and meaning of the stressor when appropriate.</td>
</tr>
<tr>
<td>The patient will implement two</td>
<td>Help the patient identify ways to restructure thoughts, modify behavior, use resources, and test new coping responses.</td>
</tr>
<tr>
<td>adaptive responses for coping with anxiety.</td>
<td>Encourage physical activity to discharge energy.</td>
</tr>
<tr>
<td></td>
<td>Include significant others as resources and social supports in helping the patient learn new coping responses.</td>
</tr>
<tr>
<td></td>
<td>Teach the patient relaxation exercises to increase control and self-reliance and reduce stress.</td>
</tr>
</tbody>
</table>

**Competent Caring**

**A Clinical Exemplar of a Psychiatric Nurse**

Madelyn Myers, MSN, RN, PMH-NP

As the night shift charge nurse on an adult psychiatric unit, I learned that the graveyard shift was anything but routine. On return to the unit after my days off, I was told that Mr. B’s behavior had deteriorated in the last few days. Mr. B was a 68-year-old man with a diagnosis of organic brain syndrome secondary to alcohol abuse. He was unable to stay in bed for more than a few minutes at a time, and he was at risk for falls because of his confusion and as a side effect of his tranquilizing medication. The previous nights the staff had found it necessary to contain Mr. B with soft restraints to keep him in bed and reduce the risk of his falling.

After shift report I made my nursing rounds, accounting for all patients and assessing the situation of the unit. Mr. B was obviously distraught and anxious. His first question to me was, “You’re not going to rope me, are you?” I sat down to talk with Mr. B to reassure him and explain that it was time for him to get ready for bed. He refused to change his clothing, stating that he just needed to walk around a little longer. I asked the therapeutic assistants if they would walk him around a while longer to try calming him down. I went to the office to start verifying the day’s orders, but I found it impossible to get much done as Mr. B was calling me and coming to the nursing office to ask questions very frequently. The staff members were also getting frustrated because he seemed very tired but would sit down for only a few minutes before he would jump up again.

After I did a few more tasks, I relieved the staff member sitting with Mr. B. I was able to get Mr. B to lie down on his bed only after he saw me take the posey off the bed and out of the room. I watched him as he lay down and he seemed to doze off to sleep almost immediately. Then again just as quickly he awoke and started out of bed. He said, “Something is very wrong with me—I’m afraid I might die.” We discussed his anxiety,
and I reassured him that one of the staff would sit with him if that would make him feel more secure. He nodded in affirmation. I sat by his bedside. He fell asleep immediately and again repeated his previous pattern of awakening with a start, but this time he just looked over, saw me, and returned to sleep.

A short while later, one of the other staff members came to relieve me. I shared with her my concern that Mr. B had been quite anxious and that my plan was to sit at his bedside and gradually move the chair back until we were sitting just outside his room but still in his line of sight. This way, he would be reassured that staff were still close by, and we could observe him if he tried to get out of bed. That night he actually slept 4 hours with only two brief awakenings. The previous nights he had only dozed for minutes at a time.

The next morning I spoke with the nurse on his team about his fear of dying and of being “roped” with the posey. I shared with her the strategy we used of sitting with him and how he was able to sleep when we stayed nearby. The new plan of care was placed in his chart for all to follow. The next few nights we continued with our plan, and each night Mr. B slept a little longer. He would even change into his pajamas before bed. He no longer started to “escalate” at bedtime. As he was sleeping better, Mr. B was also feeling better physically, and his anxiety level decreased dramatically. He required less medication for his anxiety; thus he was much more stable on his feet and no longer at risk for falls. Mr. B’s ability to perform his activities of daily living (ADLs) increased over the next week, and he was able to return to his previous living situation.

Many of his symptoms seemed to have been from sleep deprivation, high levels of anxiety, and the untoward effects of tranquilizers. This rewarding experience was not an isolated event on the night shift. It seems that many people sleep through the night and see only the shadows of the staff making rounds, but there are others for whom the care they receive during these darkened hours makes a critical difference.
References