



NMNEC Concept: **Anxiety**

Mega Concept: Health and Illness

Category: Emotional Processes

Concept Name: Anxiety

Concept Definition:

Convoy (2017) states that anxiety is “a subjective distressful experience activated by the perception of a threat, which has a potential for psychological and physiological etiology of expression” (p. 327).

Scope and Categories:

Scope: The anxiety continuum extends from No anxiety→ Mild anxiety→ Moderate anxiety→ Severe anxiety→ Panic. It can be a healthy response when it alerts a person to impending threats. It can be a negative response when it progresses from moderate anxiety to severe anxiety to panic and interferes with a person’s ability to function (Peplau, 1991). Anxiety becomes a diagnosis of an Anxiety Disorder when it meets certain Diagnostic Statistical Manual of Mental Disorders (DSM-5) criteria due to being excessive, and/or out of the norm. In some disorders, cultural context must be considered before a diagnosis can be made. Anxiety Disorders share the common features of excessive fear, anxiety, and behavioral disturbances (American Psychiatric Association [APA], 2013).

Categories:

- Separation Anxiety Disorder: is a severe reaction to separation from an attachment figure, or concern that this figure will be harmed. In children manifestations may include fear, somatic symptoms, nightmares, and/or difficulty sleeping. In adolescence, and adult’s manifestations may include cardiovascular symptoms such as feeling faint, or palpitations. The reaction is developmentally inappropriate. Culture factors must be considered when making a diagnosis (APA, 2013).
- Selective Mutism: is manifested by the persistent inability to speak in social situations, whereby speech is expected (e.g. school), although the individual speaks normally in other situations (e.g. at home). The age of onset is usually before the age of five. This disturbance impairs functioning, and social/or interactions (APA, 2013)
- Agoraphobia: is manifested by marked anxiety or fear whereby the individual avoids two or more of the following situations that cause severe distress: use of public transportation, being in an open space, being in an enclosed space, standing in a crowd or in line, or being out of the house alone (APA, 2013).



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- Panic Attack: is manifested by abrupt feelings of intense discomfort or fear; the attack reaches its peak in minutes. The attack may be accompanied by cognitive symptoms (e.g. depersonalization, derealization), physical symptoms, and/or fear of dying or losing control. The average age of onset is 22-23 years of age (APA, 2013).
- Panic Disorder: is manifested by unexpected, reoccurring, panic attacks. The person may be persistently worried or concerned about having more panic attacks; and the attack, or worry of an attack causes significant maladaptive changes in behavior. The median age of onset is 20-24 years of age (APA, 2013).
- Social Anxiety Disorder: is manifested by marked fear or anxiety of a social situation(s) whereby the person fears humiliation, embarrassment, or rejection (children may display anxiety/fear by [e.g. freezing, crying, tantrums]). The average age of onset is 13 years of age (APA, 2013).
- Specific Phobia: is manifested by marked anxiety or fear of a situation or specific object (children may display anxiety/fear by e.g. clinging, tantrums, cringing). Categories of phobic stimuli include: specific natural environment(s), animal(s), blood injection-injuries, and situational phobic stimuli. The average age of onset is between 7 and 11 years of age (APA, 2013).
- Generalized Anxiety Disorder: is manifested by excessive and persistent worry about school or occupational performance which the person feels he/she cannot control. Other symptoms may include difficulty sleeping, fatigue, difficulty concentrating, restlessness, muscle tension and/or irritability (APA, 2013).
- Substance/Medication-Induced Anxiety Disorders: this disorder is developed during, or soon after use of a medication, or intoxication or withdrawal from a substance (APA, 2013).
- Anxiety Disorder Due to Another Medical Condition: this disorder is due to the physiological effects of a disease process/medical condition (APA, 2013).

Risk Factors: (Includes populations and individual)

Populations at Greatest Risk:

- Gender: Most anxiety disorders occur in females; the female to male ratio is 2:1 (APA, 2013).
- Lifespan: Anxiety can effect persons across the lifespan: pediatric to geriatric (APA, 2013).
- Age: Some anxiety disorders may develop in childhood (e.g. Separation Anxiety Disorder, Selective Mutism, Phobic Disorder). Other disorders develop later in life.



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Individual Risk Factors:

- **Familial/genetic:** is dependent on the anxiety specific disorder (e.g. there may be susceptibility to some specific phobias, social anxiety disorder, agoraphobia). In generalized anxiety disorder, one third of the risk is genetic (APA, 2013).
- **Environmental risks:** are dependent on the specific anxiety disorder. Examples of environmental risk factors include: overprotective parenting (e.g. separation anxiety disorder, selective mutism, specific phobia, agoraphobia, generalized anxiety disorder), life stressors (e.g. separation anxiety disorder, specific phobia, panic disorder, agoraphobia), and a history of sexual/physical abuse (e.g. specific phobia, panic disorder) (APA, 2013).
- **Medical conditions:** can induce Anxiety Disorder Due to Other Medical Condition. Examples of medical conditions that can cause this problem include hyperthyroidism, hypoglycemia, congestive heart failure, pulmonary embolism, arrhythmia, chronic obstructive pulmonary disease, asthma, Vitamin B12 deficiency, neoplasms, and seizure disorders (APA, 2013).
- **Substance Use:** or withdrawal from substances can cause Substance-Induced Anxiety Disorder. Examples of substances that can cause this condition include alcohol, caffeine, cannabis, opioids, sedatives, amphetamines, and cocaine (APA, 2013).
- **Smoking:** is a risk factor for Panic Disorder (APA, 2013).

Psychological and Physiological Processes and Consequences:

- The fight or flight response is a sympathetic response to anxiety, related to the release of adrenalin. Signs of this response include tachycardia, dilation of the airways of the lungs, release of glucose from the liver, slowed peristalsis, and dilatation of the pupils (Cannon, 1935).
- **Selye's General Adaptation Syndrome:** Selye postulates that stressors are seen as threatening, and the individual reacts; there are limited resources to cope with stress. Three phases can occur: 1) alarm: reaction to stress 2) resistance: restoration of energy, and self-repair, and 3) exhaustion; this phase three can result in death or disease (Selye, 1956).
- **Neurobiological:** The amygdala is involved in the response to anxiety. It alerts the brain to danger, which manifests, for self-preservation, with anxiety or fear. Neurochemicals also facilitate regulation of anxiety. These include gamma-aminobutyric acid (GABA), epinephrine, norepinephrine, serotonin, and dopamine (Halter, 2018).



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- Defense mechanisms: An individual may respond to anxiety by utilizing various defense mechanisms to facilitate coping with reality. Examples include conversion, denial, isolation, rationalization, and repression (Potter, 2016).

Consequences:

Peplau (1991) proposes the following consequences of anxiety:

- Mild anxiety: this state results in increased alertness with a broadened perceptual field; this is a productive state of anxiety.
- Moderate anxiety: this state results in a narrowed perceptual field; this state of anxiety enables the individual to focus on the immediate problem/problem solve.
- Severe anxiety: this state has crippling and paralyzing effects, and results in impaired judgement.
- Panic: this state is a clinical problem; and manifests with a complete loss of control, and can result in death.

The APA (2013) identifies the following as potential consequences of anxiety disorders; consequences vary dependent on the specific disorder:

- Psychological pain
- Limitation of independent activities
- Social Isolation
- Impairment in occupational, social, and/or academic functioning
- Decreased quality of life
- Disability
- Suicide: increased risk for suicidal ideation, attempts, and/or completed suicide

Assessment:

Subjective:

- -Complete a health history that includes risk factors for anxiety.
- Determine the scope of anxiety (mild, moderate, severe, or panic).
- When applicable, determine what may be causing the anxiety.
- Identify past or current stressors and the client's appraisal of stressor(s).
- Assess the client for support systems, such as the family.
- Review past or current medical diagnoses, substance use, medications, and history of a psychiatric illness.



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Objective: (Convoy, 2017)

- Perform a focused physical assessment for anxiety: e.g. hypertension, tachypnea, diaphoresis, tachycardia, gastrointestinal distress.
- Complete a mental status exam; this can reveal other manifestations of anxiety: e.g. psychomotor agitation, rapid speech, confusion, impaired short term memory.
- Examples of tools used to measure anxiety include: The Beck Anxiety Inventory for Youth, The Hamilton Anxiety Scale, and the Beck Anxiety Inventory.

Diagnostic Tests

- There are no specific tests for anxiety, however diagnostics may be used to rule out organic causes, or used to diagnose Anxiety Disorder Due to Other Medical Condition.
- Substance abuse screening may be used to facilitate a diagnosis of Substance-Induced Anxiety Disorder.

Clinical Management

Primary Prevention:

- Well visits across the lifespan
- Fostering healthy parent child relationships
- Preventive programs for substance abuse

Secondary Prevention: Screening

- Early detection
- Screening tools: As state above, several screening tools are used to assess specific age related and types of anxiety disorders (e.g. The Beck Anxiety Inventory for Youth, The Hamilton Anxiety Scale, and the Beck Anxiety Inventory).

Tertiary Prevention: Treatment

Nursing: The goal is to decrease the client's level of anxiety, and keep the individual safe.

Vacek (2015) identifies the following nursing interventions for acute states of anxiety:

- Keep the environmental stimuli to a minimum
- Have self-awareness regarding own level of anxiety
- Use concrete and simple language when communicating
- Assure the patient of security and safety
- Contain family members and/or friend's, as anxiety can be contagious



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McCaffrey (2014) identifies the following nursing interventions for anxiety:

- Assess the client's level of anxiety
- Assess the client's physical symptoms of anxiety
- If the client's thoughts or fears are irrational, give client accurate information
- Remove any immediate sources of anxiety
- Allow client to express
- Explain all procedures, interventions that directly involve the client, to the client
- Provide massage, and/or backrubs as applicable

Other nursing interventions include:

- Nurse to apply therapeutic use of self (genuine, empathetic, respectful)
- Stay with the client if moderate to severe anxiety, or panic exists; do not leave client alone as there is a risk for danger to self or others
- Complete suicide screening when applicable
- Administer psychopharmacology, and evaluate response to medications
- Provide psychoeducation on methods to decrease anxiety, and on psychopharmacology
- Refer clients with Anxiety Disorders to the National Alliance of the Mentally Ill (NAMI, 2019) for resources

Collaborative Care:

Convoy (2017) identifies the following elements of collaborative care:

- Pharmacotherapy may vary dependent on anxiety state, and/or the type of Anxiety Order. The following are medications used to treat anxiety, and or various anxiety disorders (it is important to know which medications treat which specific type of disorder):
 - B-adrenergic receptor agonists (e.g. metoprolol, clonidine, propranolol)
 - Benzodiazepines (e.g. lorazepam, diazepam, clonazepam)
 - Non benzodiazepine anxiolytics (e.g. buspirone, hydroxyzine)
 - Antidepressants (tricyclic antidepressants [TCA's], monoamine oxidase inhibitors [MAOIs], selective serotonin reuptake inhibitors [SSRI's], serotonin-norepinephine reuptake inhibitors [SNRI's])
- Psychotherapy: examples include:
 - Prolonged exposure therapy
 - Cognitive-behavioral therapy
 - Cognitive processing therapy



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- Mindfulness-based cognitive therapy
- Animal-assisted therapy
- Complementary and alternative medicine
 - Meditation
 - Spiritual practice
 - Acupuncture
 - Supplements (e.g. valerian root, St. John's Wort): caution using these with psychotropic medications

The National Institute of Mental Health [NIMH] (2019) also advises on the following:

- Support groups
- Stress management techniques

Vacek (2013) identifies other collaborative contributions to improve client outcomes:

- Vocational rehabilitation
- Psychosocial rehabilitation
- Family therapy

Model Case:

MB is a 45-year-old woman who arrived at the emergency room (ER) with complaints of dyspnea, severe chest pain, a choking sensation, sweating, nausea, and feelings of “going crazy” that she states lasted for approximately 20 minutes, and occurred just prior to arriving at the ER. She currently is not taking any medications, and denies substance use. A history and medical examination was completed including a chest x-ray, an electrocardiogram (EKG), and cardiac enzymes. Diagnostics ruled out cardiac and pulmonary problems as etiological factors. MB reported having a history of generalized anxiety disorder, and that she is going through a divorce, and is concerned about custody of her child, and finances. A diagnosis of Panic Attack is made.

Interrelated Concepts: (Vacek, 2013)

- Stress and coping: Individuals in severe anxiety states/panic are in stress overload. Many persons with anxiety have maladaptive coping responses, and the inability to mobilize, and/or manage resources.
- Mood and affect: This refers to the individual's emotional state that impacts behaviors or perceptions.



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- Behavior: anxiety with increased tension, and frustration can cause impulsive behavior, impaired judgement, and put one at risk for violence to self or others. Some anxiety disorders have an increased risk of suicidal ideation or completed suicide

Exemplars:

New Mexico Nursing Education Consortium (NMNEC) Required Exemplars:

- **Anxiety Continuum:** Extends from No anxiety→ Mild anxiety→ Moderate anxiety→ Severe anxiety→ Panic. It can be a healthy response when it alerts a person to impending threats. It can be a negative response when it progresses from moderate anxiety to severe anxiety to panic and interferes with a person's ability to function (Peplau, 1991).
- **Panic Attack:** Is manifested by abrupt feelings of intense discomfort or fear; the attack reaches its peak in minutes. The attack may be accompanied by cognitive symptoms (e.g. depersonalization, derealization), physical symptoms, and/or fear of dying or losing control. The average age of onset is 22-23 years of age (APA, 2013). The 12-month prevalence of panic attacks in the United States is 11.2% in adults (APA, 2013). Panic attacks do occur in children, but this is rare, until puberty (APA, 2013).



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