Anxiety Disorders NCLEX Review

I. Anxiety

- **Anxiety** is a normal response to stress
- It is a *subjective experience* that includes feelings of apprehension, uneasiness, uncertainty, or dread
- Anxiety occurs because of a threat that may be misperceived or misinterpreted or of a threat to identity or self-esteem.
- Anxiety may result when values are threatened or preceding new experiences

II. Anxiety as a Response to Stress

Stress is viewed as a nonspecific body response to any demand

General adaptation syndrome: an automatic physical reaction to stress mediated by the sympathetic nervous system; has three distinct stages — *alarm, resistance, and exhaustion*

1. Alarm is the initial response to a stressor

- As a result of hormonal activity, generalized physical arousal develops and physical and psychological defenses are mobilized

- The "fight-or-flight" reaction, an automatic psychological state of high anxiety mediated by the sympathetic nervous system, occurs

- Increased alertness is focused on the immediate task or threat

- The level of anxiety is mild to moderate

2. Resistance occurs when the body mobilizes resources to combat stress

- The body stabilizes and adapts to stress, but functions below optimal level

- Used of Coping and Defense Mechanism

- Coping mechanisms- efforts to manage specific demands that are appraised as threatening
- Defense mechanisms - unconscious psychological responses designed to diminish or delay anxiety and protect the person

- Psychosomatic symptoms begin to develop

- The level of anxiety is moderate to severe

3. Exhaustion occurs when adaptational resources are depleted

- Results from inability to cope with overwhelming or long-lasting stress

- Thinking becomes disorganized and illogical

- The person may experience sensory misperceptions, delusions, hallucinations, and/or reduced orientation to reality

- The level of anxiety is severe to panic

III. Levels of anxiety

1. Mild

- associated with the tension of everyday life
- The individual is alert
- The perceptual field is increased
- can be motivating, produce growth, enhance creativity, and increase learning.

1. Moderate

- The focus is on immediate concerns.
- narrows the perceptual field.
- Selective inattentiveness occurs.
- Learning and problem solving still occur.

1. Severe

- a feeling that something bad is about to happen.
- A significant narrowing in the perceptual field occurs.
- Focus is on minute or scattered details.
- All behavior is aimed at relieving the anxiety.

- Learning and problem solving are impossible.
- The individual needs direction to focus.

1. Panic

- associated with dread and terror and a sense of impending doom.
- The personality is disorganized.
- The individual is unable to communicate or function effectively.
- Increased motor activity occurs.
- Loss of rational thoughts with distorted perception occurs.
- Inability to concentrate occurs.
- If prolonged, panic can lead to exhaustion and death.

IV. Etiology

A. Biological factors

1. Anxiety results from improper functioning of the body systems involved in the normal stress response
2. Predisposition to the development of anxiety appears to be partially related to genetic factors
3. Hyperactivity of the autonomic nervous system is associated with anxiety
4. Several neurotransmitters have been associated with anxiety

- A low level of gamma-aminobutyric acid (GABA), a neurotransmitter that inhibits the reactivity of neurons, is associated with anxiety
- High levels of Norepinephrine. Norepinephrine is associated with the "fight-or-flight" reaction.

- Panic attacks, sudden episodes of symptoms such as dizziness, dyspnea, tachycardia, palpitations, and feelings of impending doom and death (high levels of Norepinephrine)

- High levels of serotonin - Obsessive-compulsive disorder

V. Management of Anxiety Disorders

PRIORITY NURSING ACTIONS

A. Actions to Take for a Client Experiencing Anxiety

1. Provide a calm environment, decrease environmental stimuli, and stay with the client.
2. Ask the client to identify what and how he or she feels.
3. Encourage the client to describe and discuss his or her feelings.
4. Help the client to identify the causes of the feelings if he or she is having difficulty doing so.
5. Listen to the client for expressions of helplessness and hopelessness.
6. Document the event, significant information, actions taken and follow-up actions, and the client's response.

B. General nursing measures

Interventions: *Mild to moderate levels*

- Help the client identify the anxiety.
- Encourage the client to talk about feelings and concerns.
- Help the client identify thoughts and feelings that occurred before the onset of anxiety.
- Encourage problem solving.
- Encourage gross motor exercise.

Interventions: *Severe to panic levels*

- Reduce the anxiety quickly.
- Use a calm manner.
- Always remain with the client.
- Minimize environmental stimuli.
- Provide clear, simple statements.
- Use a low-pitched voice.
- Attend to the physical needs of the client.
- Provide gross motor activity.
- Administer antianxiety medications as prescribed.

C. Psychopharmacology

ANTI-ANXIETY OR ANXIOLYTIC MEDICATIONS

- Antianxiety medications depress the CNS, increasing the effects of GABA, which produces relaxation and may depress the limbic system.

1. **Benzodiazepines**

- the most commonly used and most effective medications for treatment of the symptoms of anxiety
- have anxiety-reducing (anxiolytic), sedative-hypnotic, muscle-relaxing, and anti-convulsant actions
- are contraindicated in clients with acute narrow-angle glaucoma and should be used cautiously in children and older adults
- interact with other CNS medications, producing an additive effect.
- Abrupt withdrawal of benzodiazepines can be potentially life-threatening, and withdrawal should occur only under medical supervision.

Side effects:

- Daytime sedation
- Ataxia
- Dizziness
- Headaches
- Blurred or double vision
- Hypotension
- Tremor
- Amnesia
- Slurred speech
- Urinary incontinence
- Constipation
- Paradoxical CNS excitement
- Lethargy
- Behavioral change

Acute toxicity

- Somnolence
- Confusion
- Diminished reflexes and coma

- Flumazenil (Romazicon), a benzodiazepine antagonist administered intravenously, reverses benzodiazepine intoxication in 5 minutes.

- A client being treated for an overdose of a benzodiazepine may experience agitation, restlessness, discomfort, and anxiety.

Nursing Responsibilities (Benzodiazepine)

1. Monitor for motor responses such as agitation, trembling, and tension.
2. Monitor for autonomic responses such as cold clammy hands and sweating.
3. Monitor for paradoxical CNS excitement during early therapy, particularly in older adults and debilitated clients.
4. Monitor for visual disturbances because the medications can worsen glaucoma.
5. Monitor liver and renal function test results and complete blood cell counts.
6. Reduce the medication dose as prescribed for the older adult client and for the client with impaired liver function.
7. Initiate safety precautions because the older adult client is at risk for falling when taking the medication for sleep or anxiety.
8. Assist with ambulation if drowsiness or lightheadedness occurs.
9. Instruct the client that drowsiness usually disappears during continued therapy.
10. Instruct the client to avoid tasks that require alertness until the response to the medication is established.
11. Instruct the client to avoid alcohol.
12. Instruct the client not to take other medications without consulting the physician.
13. Instruct the client not to stop the medication abruptly (can result in seizure activity).

Withdrawal

1. To lessen withdrawal symptoms, the dosage of a benzodiazepine should be tapered gradually over 2 to 6 weeks.
2. Abrupt or too rapid withdrawal results in the following:

- Restlessness
- Irritability
- Insomnia
- Hand tremors
- Abdominal or muscle cramps
- Sweating
- Vomiting
- Seizures

2. **Non-benzodiazepine: Buspirone (Buspar)** is a serotonin and dopamine antagonist used in the short-term treatment of anxiety

- Buspirone is well-absorbed orally
- It generally takes 2 to 3 weeks for the anti-anxiety effects to become apparent and 4 to 6 weeks or longer for the drug to become fully effective
- Side effects of buspirone rarely occur

Common side effects include dizziness, drowsiness, headache, nausea, nervousness, light-headedness, and excitement

- Side effects generally decrease over time as the body adapts to the medication
- not habit forming and does not potentiate the depressant effects of alcohol, barbiturates, and other central nervous system (CNS) depressants
- Due to its short half-life, buspirone must be administered three times daily
- Because buspirone does not induce an immediate calming effect it shouldn't be used as a prn medication for anxiety
- Withdrawal symptoms do not occur when the drug is discontinued

3. **Beta blockers:** have a calming effect on the CNS

- are effective in *treatment of physical symptoms of anxiety*, such as tremors and tachycardia

VI. Specific Disorders

1. **Generalized Anxiety Disorder**

- unrealistic anxiety about everyday worries that persists over time and is not associated with another psychiatric or medical disorder.
- Physical symptoms occur.

Assessment

- Restlessness and inability to relax
- Episodes of trembling and shakiness
- Chronic muscular tension
- Dizziness
- Inability to concentrate
- Chronic fatigue and sleep problems
- Inability to recognize the connection between the anxiety and physical symptoms
- Client is focused on the physical discomfort.

!!! Nurses should encourage clients with generalized anxiety disorder to rethink their perceptions of the stressor, recognize that some anxiety is a normal part of life, and learn new coping mechanisms

2. Panic disorder

- produces a sudden onset of feelings of intense apprehension and dread.
- The cause usually cannot be identified.

- Severe, recurrent, intermittent anxiety attacks lasting 5 to 30 minutes occur.

Assessment

- Choking sensation
- Labored breathing
- Pounding heart
- Chest pain
- Dizziness
- Nausea
- Blurred vision
- Numbness or tingling of the extremities
- Sense of unreality and helplessness
- Fear of being trapped
- Fear of dying

Interventions

1. Remain with the client.
2. Attend to physical symptoms.
3. Assist the client to identify the thoughts that aroused the anxiety and identify the basis for these thoughts.
4. Assist the client to change the unrealistic thoughts to more realistic thoughts.
5. Use cognitive restructuring to replace distorted thinking.
6. Administer anti-anxiety medications if prescribed.

3. Post-traumatic Stress Disorder

- After experiencing a psychologically traumatic event, the individual is prone to re-experience the event and have recurrent and intrusive dreams or flashbacks.

Stressors:

- Natural disaster
- Terrorist attack
- Combat experiences
- Accidents
- Rape
- Crime or violence
- Sexual, physical, and emotional abuse

- Re-experiencing the event as flashbacks

Assessment

- Emotional numbness
- Detachment
- Depression
- Anxiety
- Sleep disturbances and nightmares
- Flashbacks of event
- Hypervigilance
- Guilt about surviving the event
- Poor concentration and avoidance of activities that trigger the memory of the event

Interventions for Posttraumatic Stress Disorder

1. Be nonjudgmental and supportive.
2. Assure client that his or her feelings and behaviors are normal reactions.
3. Assist client to recognize the association between his or her feelings and behaviors and the trauma experience.
4. Encourage client to express his or her feelings; provide individual therapy that addresses loss of control or anger issues.
5. Assist client to develop adaptive coping mechanisms and to use relaxation techniques.
6. Encourage use of support groups
7. Facilitate a progressive review of the trauma experience.
8. Encourage client to establish and re-establish relationships.
9. Inform client that hypnotherapy or systematic desensitization may be used as a form of treatment.

4. Phobias

- Irrational fear of an object or situation that persists, although the person may recognize it as unreasonable
- Associated with panic level anxiety if the object, situation, or activity cannot be avoided
- Defense mechanisms commonly used include *repression* and *displacement.*

Types

Interventions

1. Identify the basis of the anxiety.
2. Allow the client to verbalize feelings about the anxiety-producing object or situation; frequently talking about the feared object is the first step in the desensitization process.
3. Teach relaxation techniques, such as breathing exercises, muscle relaxation exercises, and visualization of pleasant situations.

4. Promote desensitization by gradually introducing the individual to the feared object or situation in small doses.
5. Always stay with the client experiencing anxiety to promote safety and security.
6. Never force the client to have contact with the phobic object or situation.

5. Obsessive-Compulsive Disorder

Obsessions: Preoccupation with persistently intrusive thoughts and ideas

Compulsions: The performance of rituals or repetitive behaviors designed to prevent some event, divert unacceptable thoughts, and decrease anxiety.

- Obsessions and compulsions often occur together and can disrupt normal daily activities.
- Anxiety occurs when one resists obsessions or compulsions and from being powerless to resist the thoughts or rituals.
- Obsessive thoughts can involve issues of violence, aggression, sexual behavior, orderliness, or religion and uncontrollably can interrupt conscious thoughts and the ability to function.

Compulsive behavior patterns (behaviors or rituals)

- Compulsive behavior patterns decrease the anxiety.
- The patterns are associated with the obsessive thoughts.
- The patterns neutralize the thought.
- During stressful times, the ritualistic behavior increases.
- Defense mechanisms include repression, displacement, and undoing.

Interventions for Obsessive-Compulsive Disorder

1. Ensure that basic needs (food, rest, grooming) are met
2. Identify situations that precipitate compulsive behavior; encourage client to verbalize concerns and feelings.
3. Be empathetic toward client and aware of his or her need to perform the compulsive behavior
4. Do not interrupt compulsive behaviors unless they jeopardize the safety of client or others (provide for client safety related to the behavior).
5. Allow time for client to perform the compulsive behavior, but set limits on behaviors that may interfere with client's physical well-being to protect client from physical harm.
6. Implement a schedule for client that distracts from the behaviors (structure simple activities, games, or tasks for client).
7. Establish a written contract that assists client to decrease the frequency of compulsive behaviors gradually.
8. Recognize and reinforce positive non-ritualistic behaviors