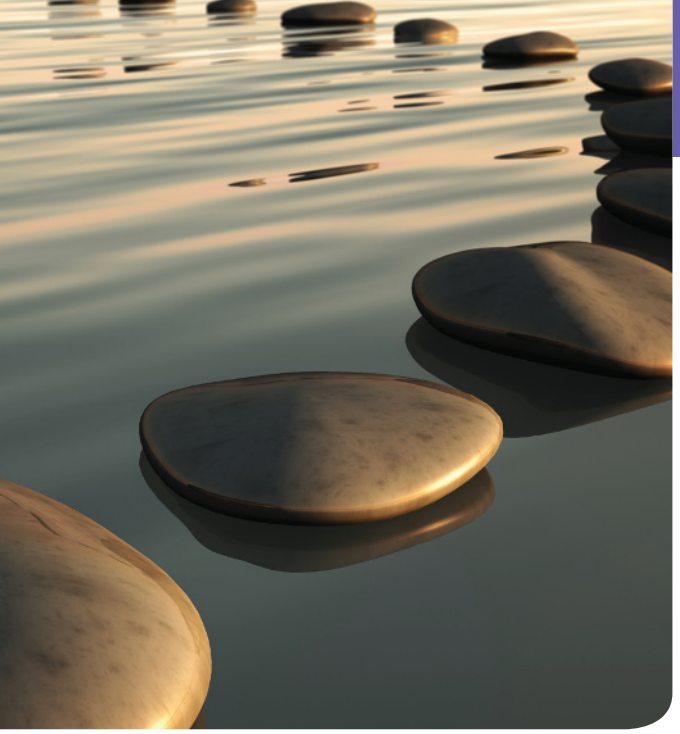

Essentials of Psychiatric Nursing

Third Edition

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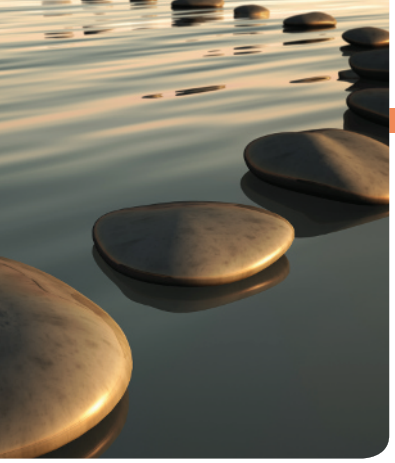
To Jim and family, with love and pride.

—Mary Ann Boyd

To Brock and Drake, who inspire me and make me so proud.

—Rebecca Luebbert



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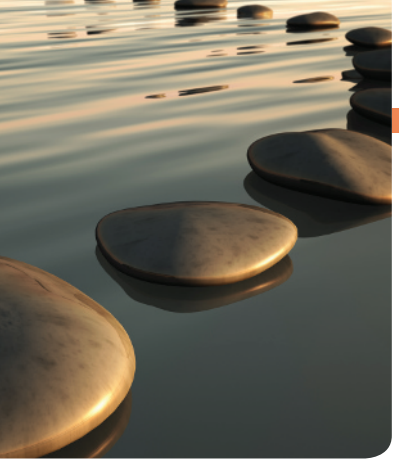

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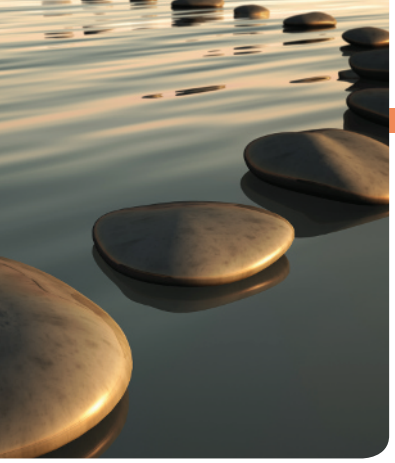

Preface

Mental health of individuals, families, and communities is being shaped by major events including a pandemic, climate change, and violence. Opioid addiction is continuing to be a major societal challenge in the United States. Suicide is touching families in small towns and large communities. Although mental health needs are escalating during these challenging times, mental health resources are declining.

Psychiatric–mental health nursing knowledge and skills are more important now than ever to nursing practice. All nurses must be prepared to provide appropriate mental health care. Today the practicing nurse is required to have an extensive understanding of mental health disorders and the impact of mental illness and treatment on the quality of life of the individual and family. Recovery from mental illness is a journey involving a partnership between health care professionals and the person with a mental health disorder. Nurses need to develop skills to partner with persons with mental health disorders. These individuals not only need support and treatment to recover from a serious disorder but also help in eradicating the stigma associated with mental illness.

Essentials of Psychiatric Nursing, Third Edition, provides students with the evidence-based knowledge to develop recovery-oriented nursing interventions with the person with mental illness. This book incorporates updated content emphasizing communication skills, mental health promotion, and current, evidence-based, recovery-oriented nursing care of persons with common mental health disorders. The book presents complex concepts in easy-to-understand language with multiple examples and explanations. The text is filled with meaningful information and is applicable to all areas of nursing practice.

Pedagogical features in the book plus dynamic online resources at http://thepoint.lww.com/BoydEssentials3e offer opportunities for students to challenge the stigma associated with mental disorders; please see discussions of these later in this preface. Case studies are central to the mental disorder discussions and provide students with the opportunity to link real-life experiences to theoretical concepts.

Our goal is to prepare nursing leaders who challenge the status quo, partner with their patients in the delivery of care, and use the latest evidence in their nursing practice.

TEXT ORGANIZATION

Unit I, Essentials of Mental Health Care, discusses mental health and mental disorders as they relate to the concept of wellness. In Chapter 1, students will learn about the concepts of stigma and recovery. Chapter 2 discusses cultural communities and spiritual issues, and Chapter 3 covers patient rights and legal issues.

Unit II, Psychiatric–Mental Health Nursing Frameworks, provides a foundation for beginning practice with an explanation of ethics, standards, and nursing in Chapter 4; the theoretical foundation in Chapter 5; and the biologic foundations in Chapter 6. Chapter 7 expands content related to recovery and person-centered care.

Unit III, Knowledge and Skills of Psychiatric–Mental Health Nursing, contains two communication chapters: Chapter 8, which focuses on therapeutic communication, and Chapter 9, which discusses the nurse–patient relationship. In addition, in this unit students will learn about psychiatric–mental health nursing assessment with a brief overview of typical nursing interventions in Chapter 10, pharmacology and other biologic interventions in Chapter 11, and group interventions in Chapter 12.

The chapters in Unit IV, Prevention of Mental Disorders, are not limited to persons with mental disorders. Content in this unit is applicable to persons in all nursing practice settings. Chapter 13 presents a model of stress that is supported by strong evidence and that can be applied to all areas of nursing. Chapter 14 explains how to understand and manage angry and aggressive patients. Content in the other chapters in this unit, including crisis intervention (Chapter 15) and suicide prevention (Chapter 16), is applicable to care of persons with or without mental disorders. This unit also includes an in-depth chapter (Chapter 17) on mental health care of survivors of violence.

The bulk of the content related to mental disorders is found in Unit V, Care and Recovery for Persons With Psychiatric Disorders, which consists of 12 chapters (Chapters 18 through 29). Each chapter discusses a mental disorder(s) and identifies priority nursing assessment and intervention strategies to promote recovery of persons with mental illness. Each chapter includes a discussion on clinical judgment for a high-risk patient. Case studies are threaded throughout each chapter to demonstrate,

in easy-to-understand language, the concepts being discussed. For some of these cases, videos at http://thepoint.lww.com/Boyd Essentials3e show nurses interacting with persons with the disorder(s) discussed in the chapter.

Unit VI, Care of Special Populations, consists of three chapters discussing mental health needs of special populations. Chapter 30 focuses on the mental disorders of children, and Chapter 31 describes the neurocognitive disorders of older adults. Chapter 32 is a new chapter that highlights the special mental health care needs of veterans.

PEDAGOGICAL FEATURES

Essentials of Psychiatric Nursing incorporates a multitude of pedagogical features to focus and direct student learning.

Introductory and Chapter-Closing Features

- **Expanded Table of Contents** allows readers to find and refer to concepts from one location.
- **Learning Objectives, Key Terms,** and **Key Concepts** in the chapter openers cue readers to what will be encountered and what is important to understand in each chapter.
- **Summary of Key Points** lists at the end of each chapter provide quick access to important chapter content to facilitate study and review.
- **Critical Thinking Challenges** ask questions that require students to think critically about chapter content and apply psychiatric nursing concepts to nursing practice.
- **Movies** list current examples of movies that depict various mental health disorders and that are widely available for rent or purchase. Viewing points are provided to serve as a basis for discussion in class and among students.

Other Special Features

- **NCLEX Notes** help students focus on important application areas to prepare for the NCLEX.
- **Case Studies** are threaded throughout the Unit V disorder chapters. Each chapter begins with a case study that is highlighted throughout the chapter. This case study is used as the prototype for that chapter's Nursing Care Plan (at http://thepoint.lww.com/Boyd Essentials3e) and Therapeutic Dialogue. For some chapters, an accompanying video on thePoint is provided so students can view the symptoms and the nursing care for a patient with a specific disorder. For your convenience, a list of all the case studies, with their location in the book, appears in the "Case Studies in This Book" section later in this front matter.
- **Unfolding Patient Stories,** written by the National League for Nursing, are an engaging way to begin meaningful conversations in the classroom. These vignettes, which appear at the end of the first chapter in each unit, feature patients from Wolters Kluwer's vSim for Nursing | Mental Health (codeveloped by Laerdal Medical) and DocuCare products; however, each Unfolding Patient Story in the book stands alone, not requiring purchase of these products. For your convenience, a list of all these case studies, along with their location in the book, appears in the "Case Studies in This Book" section later in this front matter.
- **Emergency Care Alerts** highlight important situations in psychiatric nursing care that the nurse should recognize as emergencies.
- **Evidence-Based Nursing Care for Selected Disorders** sections provide an in-depth study of the more commonly occurring major psychiatric disorders.
- **Nursing Care Plans,** based on the case studies in the book and available at http://thepoint.lww.com/BoydEssentials3e, present clinical examples of patients with a particular diagnosis and demonstrate plans of care that follow patients through various diagnostic stages and care delivery settings.
- **Research for Best Practice** boxes highlight today's focus on evidence-based practice for *best practice*, presenting findings and implications of studies that are applicable to psychiatric nursing practice.
- **Therapeutic Dialogue** boxes compare and contrast therapeutic and nontherapeutic conversations to encourage students by example to develop effective communication skills.
- **Psychoeducation Checklists** identify content areas for patient and family education related to specific disorders and their treatment. These checklists support critical thinking by encouraging students to develop patient-specific teaching plans based on chapter content.
- **Clinical Vignette** boxes present reality-based clinical portraits of patients who exhibit the symptoms described in the text. Questions are posed to help students express their thoughts and identify solutions to issues presented in the vignettes.
- **Drug Profile** boxes present a thorough picture of commonly prescribed medications for patients with mental health problems. Examples include lorazepam (Ativan), an anxiolytic, and mirtazapine (Remeron), an antidepressant. The profiles complement the text discussions of biologic processes known to be associated with various mental health disorders.
- **Key Diagnostic Characteristics** summaries describe diagnostic criteria, target symptoms, and associated findings for select disorders, described in the *DSM-5-TR* by the American Psychiatric Association.
- **Diagrams, illustrations, and photos** colorfully illustrate the interrelationship of the biologic, psychological, and social domains of mental health and illness.
- **Patient education, family,** and **emergency icons** highlight content related to these topics to help link concepts to practice.

A COMPREHENSIVE PACKAGE FOR TEACHING AND LEARNING

To further facilitate teaching and learning, a carefully designed ancillary package has been developed to assist faculty and students.

Instructor Resources

Tools to assist you with teaching your course are available upon adoption of this text at http://thepoint.lww.com/BoydEssentials3e.

- The **Test Generator** lets you put together exclusive new tests from a bank containing hundreds of questions to help you in assessing your students' understanding of the material. Test questions correspond to chapter learning objectives.
- Sample **Syllabi** provide guidance for structuring your course.
- An **e-book** allows access to the book's full text and images online.
- **Access to all Student Resources** is also provided.
- An extensive collection of materials is provided for each book chapter:
  - **PowerPoint Presentations** provide an easy way for you to integrate the textbook with your students' classroom experience, either via slide shows or handouts. Multiple choice and true/false questions are integrated into the presentations to promote class participation and allow you to use i-clicker technology.
  - **Guided Lecture Notes** walk you through the chapters, objective by objective, and provide you with corresponding PowerPoint slide numbers.
  - **Discussion Topics** (and suggested answers) can be used as conversation starters or in online discussion boards.
  - **Assignments** (and suggested answers) include group, written, clinical, and web assignments.
  - **Case Studies** with related questions (and suggested answers) give students an opportunity to apply their knowledge to a client case similar to one they might encounter in practice.
  - An **Image Bank** allows you to use the photographs and illustrations from this textbook in your PowerPoint slides or as you see fit in your course.
  - Plus a **QSEN Map**, an **AACN Essentials Map**, and **Learning Objectives** from the textbook.

Student Resources

An exciting set of free resources is available to help students review and apply important concepts. Students can access these resources at http://thepoint.lww.com/BoydEssentials3e using the codes printed in the front of their textbooks.

- As indicated in the table of contents and in the appropriate places in the book, the following are found on the book's companion website at http://thepoint.lww.com/BoydEssentials3e: **Chapter 7** (Recovery Framework for Psychiatric–Mental Health Nursing), **Chapter 28** (Sleep–Wake Disorders: Nursing Care of Persons With Insomnia and Sleep Problems), and **Chapter 29** (Sexual Disorders: Nursing Care of Persons With Sexual Dysfunction).
- **Watch & Learn Videos:**
  - **Online video series,** *Lippincott Theory to Practice Video Series: Psychiatric–Mental Health Nursing*, includes videos of true-to-life patients displaying mental health disorders, allowing students to gain experience and a deeper understanding of mental health patients. The video series allows viewing of complete patient interviews and also gives the opportunity to view snippets of those interviews, for closer analysis or classroom discussion. The innovative videos feature patients found in the book and explore such topics as depression, eating disorders, and addiction.
  - A **Watch & Learn Video Clip** on cognitive functions is included from *Lippincott Video Guide to Psychiatric–Mental Health Nursing Assessment*.
- **Nursing Care Plans** based on the case studies in the book present clinical examples of patients with a particular diagnosis and demonstrate plans of care that follow patients through various diagnostic stages and care delivery settings.
- **Journal Articles** provided for each chapter offer access to current research available in Wolters Kluwer journals.

vSim for Nursing

vSim for Nursing, jointly developed by Laerdal Medical and Wolters Kluwer, offers innovative scenario-based learning modules consisting of web-based virtual simulations, course learning materials, and curriculum tools designed to develop critical thinking skills and promote clinical confidence and competence. vSim for Nursing | Mental Health includes 10 mental health scenarios authored by the National League for Nursing. Students can progress through suggested readings, pre- and post-simulation assessments, documentation assignments, and guided reflection questions, and will receive an individualized feedback log immediately upon completion of the simulation. Throughout the student learning experience, the product offers remediation back to trusted Lippincott resources, including *Psychiatric–Mental Health Nursing*, as well as Lippincott Nursing Advisor and Lippincott Nursing Procedures—two online, evidence-based, clinical information solutions

used in health care facilities throughout the United States. This innovative product provides a comprehensive patient-focused solution for learning and integrating simulation into the classroom.

Contact your Wolters Kluwer sales representative or visit http://thepoint.lww.com/vsim for options to enhance your mental health nursing course with vSim for Nursing.

Lippincott DocuCare

Lippincott DocuCare combines web-based academic EHR simulation software with clinical case scenarios, allowing students to learn how to use an EHR in a safe, true-to-life setting, while enabling instructors to measure their progress. Lippincott DocuCare's nonlinear solution works well in the classroom, simulation lab, and clinical practice.

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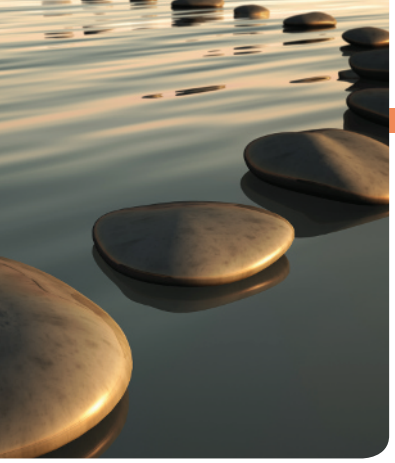
A Comprehensive, Digital, Integrated Course Solution

Lippincott® CoursePoint+ is an integrated, digital curriculum solution for nursing education that provides a completely interactive experience geared to help students understand, retain, and apply their course knowledge and be prepared for practice. The time-tested, easy-to-use, and trusted solution includes engaging learning tools, evidence-based practice, case studies, and in-depth reporting to meet students where they are in their learning, combined with the most trusted nursing education content on the market to help prepare students for practice. This easy-to-use digital learning solution of *Lippincott® CoursePoint+*, combined with unmatched support, gives instructors and students everything they need for course and curriculum success!

Lippincott® CoursePoint+ includes:

- Leading content provides a variety of learning tools to engage students of all learning styles.
- A personalized learning approach gives students the content and tools they need at the moment they need it, giving them data for more focused remediation and helping to boost their confidence and competence.
- Powerful tools, including varying levels of case studies, interactive learning activities, and adaptive learning powered by PrepU, help students learn the critical thinking and clinical judgment skills to help them become practice-ready nurses.
- Preparation for Practice tools improve student competence, confidence, and success in transitioning to practice.
  - vSim for Nursing: Co-developed by Laerdal Medical and Wolters Kluwer, vSim for Nursing simulates real nursing scenarios and allows students to interact with virtual patients in a safe, online environment.
  - Lippincott Advisor for Education: With over 8,500 entries covering the latest evidence-based content and drug information, Lippincott Advisor for Education provides students with the most up-to-date information possible, while giving them valuable experience with the same point-of-care content they will encounter in practice.
- Unparalleled reporting provides in-depth dashboards with several data points to track student progress and help identify strengths and weaknesses.
- Unmatched support includes training coaches, product trainers, and nursing education consultants to help educators and students implement CoursePoint+ with ease.



Acknowledgments

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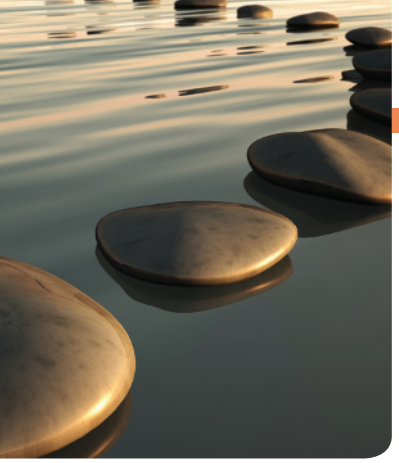
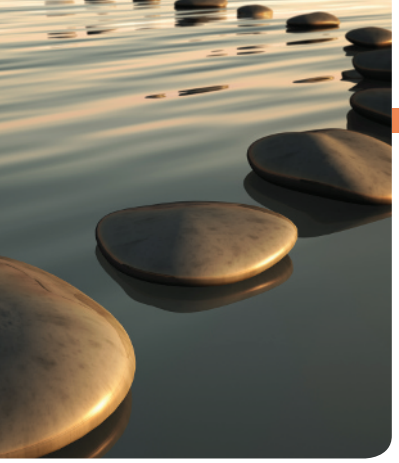


Contents



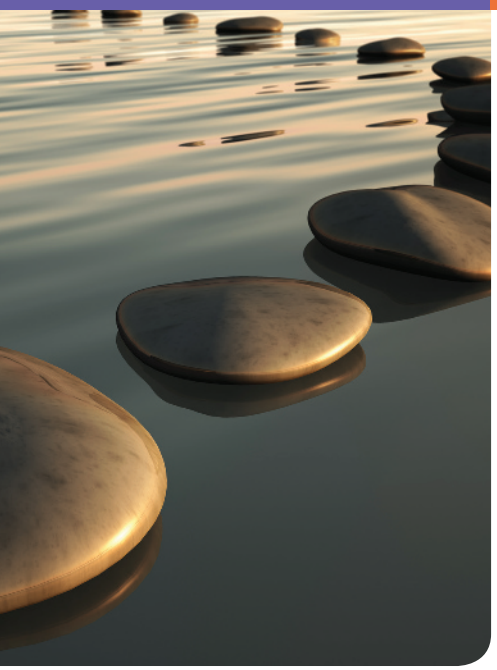
Case Studies in This Book

CASES THAT UNFOLD ACROSS CHAPTERS

CASES THAT UNFOLD WITHIN CHAPTERS

UNIT V

CARE AND RECOVERY FOR PERSONS WITH PSYCHIATRIC DISORDERS



18

Anxiety Disorders

Nursing Care of Patients With Anxiety, Phobia, and Panic

Mary Ann Boyd

KEY CONCEPTS

- anxiety
- panic
- phobia
- Physical symptoms

LEARNING OBJECTIVES

After studying this chapter, you will be able to:

1. Discuss the role of anxiety and panic in mental disorders.
2. Delineate the clinical symptoms and course of panic disorder, including phobias.
3. Analyze the primary theories explaining panic disorder and their relationship to anxiety.
4. Develop strategies to establish a patient-centered, recovery-oriented therapeutic relationship with a person with a panic disorder.
5. Apply a person-centered, recovery-oriented nursing process for persons with a panic disorder.
6. Identify medications used to treat people with a panic disorder and evaluate their effectiveness.
7. Develop wellness strategies for persons with a panic disorder.
8. Differentiate the type of mental health care provided in emergency care, inpatient-focused care, community care, and virtual mental health care.
9. Discuss the importance of integrated health care for persons with panic disorder.
10. Describe other anxiety disorders.

KEY TERMS

• Agoraphobia • Depersonalization • Exposure therapy • Flooding • Implosive therapy • Interoceptive conditioning • Panic attacks • Panic control treatment • Positive self-talk • Reframing • Specific phobia disorder • Social anxiety disorder • Systematic desensitization

Case Study: Doug

Doug is a 50-year-old man who lives with his wife Norma and two sons; Greg, a sophomore in college, and Leon, a high school student. Norma was recently laid off from her job and has been unable to find employment. The family is now experiencing financial and marital problems. Leon was recently expelled from school for drug and alcohol use. Doug had an argument with his boss and is afraid that he will lose his job. He appears at the emergency department for chest pain and is convinced he is having a heart attack. All lab test results are normal. Consider how the nurse can help Doug deal with his health issues.

Anxiety is part of many emotional problems and mental disorders. At one time, most mental conditions with anxiety aspects were categorized as "anxiety disorders," but today anxiety disorders have been redefined. Trauma–stressor-related disorder and obsessive–compulsive disorder, both previously identified as anxiety disorders, are now categorized as separate disorders (American Psychiatric Association [APA], 2022). Trauma- and stressor-related disorders, as well as dissociative disorders, are discussed in Chapter 19. Obsessive–compulsive disorders are discussed in Chapter 20. In this chapter, panic disorder is highlighted.

NORMAL VERSUS EXAGGERATED ANXIETY RESPONSE

Anxiety is an unavoidable human condition that takes many forms and serves different purposes. Anxiety can be positive and can motivate one to act, or it can produce paralyzing fear, causing inaction. *Normal anxiety* is described as being of realistic intensity and duration for the situation and is followed by relief behaviors intended to reduce or prevent more anxiety (Peplau, 1989). A "normal anxiety response" is appropriate to the situation and can be used to help the individual identify which underlying problem has caused the anxiety.

KEYCONCEPT **Anxiety** is an uncomfortable feeling of apprehension or dread that occurs in response to internal or external stimuli; it can result in physical, emotional, cognitive, and behavioral symptoms.

During a perceived threat, rising anxiety levels cause physical and emotional changes in all individuals. A normal emotional response to anxiety consists of three parts: physiologic arousal, cognitive processes, and coping strategies. Physiologic arousal, or the fight-or-flight response, is the signal that an individual is facing a threat. Cognitive processes decipher the situation and decide whether the perceived threat should be approached or avoided. Coping strategies are used to resolve the threat. Box 18.1 summarizes many physical, affective, cognitive, and behavioral symptoms associated with anxiety. The factors that determine whether anxiety is a symptom of a mental disorder include the intensity of anxiety relative to the situation, the trigger for the anxiety, and the particular symptom clusters that manifest the anxiety. Table 18.1 describes the four degrees of anxiety and associated perceptual changes and patterns of behavior. Anxiety is a component of all the disorders discussed in this chapter.

TABLE 18.1 DEGREES OF ANXIETY

Degree of Anxiety	Effects on Perceptual Field and on Ability to Focus Attention	Observable Behavior
Mild	Perceptual field widens slightly. Able to observe more than before and to see relationships (make connection among data). Learning is possible.	Is aware, alert, sees, hears, and grasps more than before. Usually able to recognize and identify anxiety easily.
Moderate	Perceptual field narrows slightly. Selective inattention: does not notice what goes on peripheral to the immediate focus but can do so if attention is directed there by another observer.	Sees, hears, and grasps less than previously. Can attend to more if directed to do so. Able to sustain attention on a particular focus; selectively inattentive to contents outside the focal area. Usually able to state, "I am anxious now."
Severe	Perceptual field is greatly reduced. Tendency toward dissociation: to not notice what is going on outside the current reduced focus of attention; largely unable to do so when another observer suggests it.	Sees, hears, and grasps far less than previously. Attention is focused on a small area of a given event. Inferences drawn may be distorted because of inadequacy of observed data. May be unaware of and unable to name anxiety. Relief behaviors generally used.
Panic (e.g., terror, horror, dread, uncanniness, awe)	Perceptual field is reduced to a detail, which is usually "blown up," that is, elaborated by distortion (exaggeration), or the focus is on scattered details; the speed of the scattering tends to increase. Massive dissociation, especially of contents of self-system. Felt as an enormous threat to survival. Learning is impossible.	Says, "I'm in a million pieces," "I'm gone," or "What is happening to me?" Perplexity, self-absorption. Feelings of unreality. Flights of ideas or confusion. Fear. Repeats a detail. Many relief behaviors used automatically (without thought). The enormous energy produced by panic must be used and may be mobilized as rage. May pace, run, or fight violently. With dissociation of contents of self-system, there may be a very rapid reorganization of the self, usually going along pathologic lines (e.g., a "psychotic break" is usually preceded by panic).

Adapted with permission from Peplau, H. (1989). Theoretical constructs: Anxiety, self, and hallucinations. In O'Toole, A., & Welt, S. (eds.). *Interpersonal theory in nursing practice: Selected works of Hildegarde E.* Peplau. Springer.

BOX 18.1

Symptoms of Anxiety

PHYSICAL SYMPTOMS

Cardiovascular

Sympathetic

Palpitations
Heart racing
Increased blood pressure

Parasympathetic

Actual fainting
Decreased blood pressure
Decreased pulse rate

Respiratory

Rapid breathing
Difficulty getting air
Shortness of breath
Pressure of chest
Shallow breathing
Lump in throat
Choking sensations
Gasping
Spasm of bronchi

Neuromuscular

Increased reflexes
Startle reaction
Eyelid twitching
Insomnia
Tremors
Rigidity
Spasm
Fidgeting
Pacing
Strained face
Unsteadiness
Generalized weakness
Wobbly legs
Clumsy motions

Skin

Flushed face
Pale face
Localized sweating (palm region)
Generalized sweating
Hot and cold spells
Itching

Gastrointestinal

Loss of appetite
Revulsion about food
Abdominal discomfort
Diarrhea
Abdominal pain
Nausea
Heartburn
Vomiting

Eyes

Dilated pupils

Urinary Tract Parasympathetic

Pressure to urinate
Increased frequency of urination

AFFECTIVE SYMPTOMS

Edgy
Impatient
Uneasy
Nervous
Tense
Wound-up
Anxious
Fearful
Apprehensive
Scared
Frightened
Alarmed
Terrified
Jittery
Jumpy

COGNITIVE SYMPTOMS

Sensory-Perceptual

Mind is hazy, cloudy, foggy, dazed
Objects seem blurred or distant
Environment seems different or unreal
Feelings of unreality
Self-consciousness
Hypervigilance

Thinking Difficulties

Cannot recall important things
Confused
Unable to control thinking
Difficulty concentrating
Difficulty focusing attention
Distractibility
Blocking
Difficulty reasoning
Loss of objectivity and perspective
Tunnel vision

Conceptual

Cognitive distortion
Fear of losing control
Fear of not being able to cope
Fear of physical injury or death
Fear of mental disorder
Fear of negative evaluations
Frightening visual images
Repetitive fearful ideation

BEHAVIORAL SYMPTOMS

Inhibited
Tonic immobility
Flight
Avoidance
Speech dysfluency
Impaired coordination
Restlessness
Postural collapse
Hyperventilation

Adapted from Beck, A. T., & Emery, C. (1985). *Anxiety disorders and phobias: A cognitive perspective* (pp. 23–27). Basic Books.

PHOBIAS

KEYCONCEPT **Phobia** is an irrational fear of an object, person, or situation that leads to a compelling avoidance.

The development of a phobia may be the outcome of extreme anxiety. Phobias are often present in anxiety disorders but may also develop into a specific phobia disorder (discussed later).

Defense Mechanisms and Anxiety

Defense mechanisms are used to reduce anxiety by preventing or diminishing unwanted thoughts and feelings. See Chapter 8 for definitions. Defense mechanisms can be helpful in coping with everyday problems, but they become problematic when overused. The first step is identifying a person's use of defense mechanisms. The next step is determining whether the reasons the defense mechanisms are being used support healthy coping or are detrimental to a person's health. What may be healthy for one person may be unhealthy for another. See Table 18.2.

OVERVIEW OF ANXIETY DISORDERS

The primary symptoms of anxiety disorders are fear and anxiety. Even though symptoms of anxiety disorders can be found in healthy individuals, an anxiety disorder is diagnosed when the fear or anxiety is excessive or out of proportion to the situation. An individual's ability to work and interpersonal relationships may be impaired. Anxiety disorders are differentiated by the situation or objects that provoke fear, anxiety, or avoidance behavior and related cognitive thoughts (APA, 2022).

TABLE 18.2 CONSEQUENCES OF DECREASING ANXIETY USING DEFENSE MECHANISMS

Defense Mechanism	Positive Consequences	Negative Consequences
Altruism	Satisfies internal needs through helping others	Prevents examination of underlying fears or concerns
Denial	Avoids feelings associated with recognizing a problem	Avoidance of major problem that should be addressed
Displacement	By taking out frustrations on an unsuspecting or vulnerable person, animal, or object, anxiety is reduced and the individual is protected from anticipated retaliation from the source of the frustration	Does not deal with problem and inappropriately expresses feelings toward a more vulnerable person or object
Intellectualization	Able to analyze events in a distant, objective, analytical way	Inability to acknowledge feelings that may be interfering with relationships
Projection	By assigning unwanted thoughts, feelings or behaviors to another person or object, the individual does not have to acknowledge undesirable or unacceptable thoughts or feelings	Does not acknowledge undesirable or unwanted feelings or thoughts and can act on inaccurate interpretation of the other person's thoughts and behaviors
Rationalization	Avoids anxiety by explaining an unacceptable or disappointing behavior or feeling in a logical, rationale way. May protect self-esteem and self-concept	Avoids the reality of a situation, which may be detrimental to the individual
Reaction Formation	Reduces anxiety by taking the opposite feeling. Hides true feelings, which may be appropriate in many situations	Unable to acknowledge personal feelings about others, which leads to negative consequences
Regression	When stressed, abandons effective coping strategies and reverts to behaviors used earlier in development. These strategies are comfortable and may be effective	May reengage in detrimental behaviors such as smoking, drinking, or inappropriate interpersonal responses leading to ineffective coping
Repression	Avoids unwanted thoughts and anxiety by blocking thoughts, experiences from conscious awareness	Cannot recall traumatic events that should be addressed to be healthy (i.e., rape)
Sublimation	Avoids anxiety and channels maladaptive feelings or impulses into socially acceptable behaviors. Maintains socially acceptable behavior	By not recognizing maladaptive feelings, the individual cannot address underlying feelings
Suppression	Reduces anxiety by intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences. Useful in many situations such as test-taking situations	Avoiding problem situation prevents finding a solution to the problem

Anxiety disorders are the most common of the psychiatric illnesses treated by health care providers. Approximately 40 million American adults (older than 18 years old) or about 18.1% of this age group within a given year have an anxiety disorder. Direct and indirect costs of treating anxiety disorders amount to tens of billions of dollars. Women experience anxiety disorders more often than men by a 2:1 ratio. Anxiety disorders may also be associated with other mental or physical comorbidities, such as heart disease, respiratory disease, and mood disorders (Penninx et al., 2021). The relationship between depression and anxiety disorders is particularly strong. A single patient may concurrently have more than one anxiety disorder or other psychiatric disorders as well.

Anxiety disorders tend to be chronic and persistent, with full recovery more likely among those who do not have other mental or physical disorders (Andreescu & Lee, 2020). Anxiety disorders tend to first episode in late adolescence or young adult.

Anxiety Disorders Across the Lifespan

Prompt identification, diagnosis, and treatment of individuals with anxiety disorders may be difficult for special populations such as children and older adult patients. Often, the symptoms suggestive of anxiety disorders may go unnoticed by caregivers or are misdiagnosed because they mimic cardiac or pulmonary pathology rather than a psychological disturbance. Children and adolescents are discussed in Chapter 30; older adults are discussed in Chapter 31.

Children and Adolescents

Anxiety disorders are among the most common conditions of children and adolescents. If left untreated, symptoms persist and gradually worsen and sometimes lead to suicidal ideation and suicide attempts, early parenthood, drug and alcohol dependence, and educational underachievement later in life (Carballo et al., 2020).

Separation anxiety disorder (i.e., excessive fear or anxiety concerning separation from home or attachment figures) usually first occurs in childhood. Affected children experience extreme distress when separated from home or attachment figures, worry about them when separated from them, and worry about untoward events (i.e., getting lost) and what will happen to them. This disorder is discussed in Chapter 30.

A rare disorder typically seen in childhood is selective mutism, in which children do not initiate speech or respond when spoken to by others (APA, 2022). Children with this disorder are often very anxious when asked to speak in school or read aloud. They may suffer academic impairment because of their inability to communicate with others.

LGBTQIA+ Persons

LGBTQIA+ persons experience significant health disparities especially in access to mental health care. Anxiety and depression are significantly higher in this group than in non-LGBTQIA+persons. Widespread discrimination and unemployment contribute to the health inequity and mental health conditions of these individuals (Bretherton et al., 2021). Negative media depiction is associated with clinically significant symptoms of depression, anxiety PTSD and psychological (Hughto et al., 2021).

Older Adults

Generally speaking, the prevalence of anxiety disorders declines with age. However, in the older adult population, rates of anxiety disorders are as high as mood disorders, which commonly co-occur. This combination of depressive and anxiety symptoms has been shown to decrease social functioning, increase somatic (physical) symptoms, and increase depressive symptoms (Meuret et al., 2020). In one study, nearly half of primary care patients with chronic pain had at least one attendant anxiety disorder. Detecting and treating anxiety is an important component of pain management (Kroenke et al., 2019). Because the older adult population is at risk for suicide, special assessment of anxiety symptoms is essential.

PANIC DISORDER

Panic is an extreme, overwhelming form of anxiety often experienced when an individual is placed in a real or perceived life-threatening situation. Panic is normal during periods of threat but is abnormal when it is continuously experienced in situations that pose no real physical or psychological threat. Some people experience heightened anxiety because they fear experiencing another panic attack. This type of panic interferes with the individual's ability to function in everyday life and is characteristic of panic disorder.

KEYCONCEPT **Panic** is a normal but extremely overwhelming form of anxiety, often experienced when an individual is placed in a real or perceived life-threatening situation.

Clinical Course

The onset of panic disorder is typically between 20 and 24 years of age. The disorder usually surfaces in childhood but may not be diagnosed until later. Panic disorder is treatable, but studies have shown that even

after years of treatment, many people remain symptomatic. In some cases, symptoms may even worsen (APA, 2022).

Panic Attacks

Panic attacks are characteristic of panic disorder. A panic attack is a sudden, discrete period of intense fear or discomfort that reaches its peak within a few minutes and is accompanied by significant physical discomfort and cognitive distress (APA, 2022). Panic attacks usually peak in about 10 minutes but can last as long as 30 minutes before returning to normal functioning. The physical symptoms include palpitations, chest discomfort, rapid pulse, nausea, dizziness, sweating, paresthesias (burning, tickling, pricking of skin with no apparent reason), trembling or shaking, and a feeling of suffocation or shortness of breath. Cognitive symptoms include disorganized thinking, irrational fears, **depersonalization** (being detached from oneself), and a decreased ability to communicate. Usually, feelings of impending doom or death, fear of going crazy or losing control, and desperation ensue.

The physical symptoms can mimic those of a heart attack. Individuals often seek emergency medical care because they feel as if they are dying, but most have negative cardiac workup results. People experiencing panic attacks may also believe that the attacks stem from an underlying major medical illness (APA, 2022). Even with medical testing and assurance of no underlying disease, they often remain unconvinced.

Remember Doug?

He had chest pains and believed he was having a heart attack. How can you help Doug recognize that even though he is not having a heart attack, his symptoms are serious and that his panic attack could indicate an underlying anxiety disorder? Why wouldn't you tell him that everything is normal?

KEYCONCEPT **Physical symptoms** of panic attack are similar to cardiac emergencies. These symptoms are physically taxing and psychologically frightening to patients. Recognition of the seriousness of panic attacks should be communicated to the patient.

In a panic disorder, recurrent unexpected panic attacks are followed by persistent concern about experiencing subsequent panic attacks. Because of fear of future attacks, these affected individuals modify normal behaviors to avoid future attacks (APA, 2022). Panic attacks are either expected with an obvious cue or trigger or unexpected with no such obvious cue. The first panic attack is usually associated with an identifiable cue (e.g., anxiety-provoking medical conditions, such as asthma, or in initial trials of illicit substance use), but subsequent attacks are often unexpected without any obvious cue (Box 18.2). Panic attacks not only occur in panic disorder but can also occur in other mental disorders such as depression, bipolar disease, eating disorders, and some medical conditions such as cardiac or respiratory disorders (APA, 2022).

BOX 18.2 CLINICAL VIGNETTE

Panic Disorder

Susan, age 22, has experienced several life changes, including a recent engagement, loss of her father to cancer and heart disease, graduation from college, and entrance to the workforce as a computer programmer in a large inner-city company. Because of her active lifestyle, her sleep habits have been poor. She frequently uses sleeping aids at night and now drinks a full pot of coffee to start each day. She continues to smoke to "relieve the stress." While sitting in heavy traffic on the way to work, she suddenly experienced chest tightness, sweating, shortness of breath, feelings of being "trapped," and foreboding that she was going to die. Fearing a heart attack, she went to an emergency department, where her discomfort subsided within a half hour. After several hours of testing, the doctor informed her that her heart was healthy. During the next few weeks, she experienced several episodes of feeling trapped and slight chest discomfort on her drive to work. She fears future "attacks" while sitting in traffic and while in her crowded office cubicle.

What Do You Think?

- What risk factors does Susan have that might contribute to the development of panic attacks?
- What lifestyle changes do you think would help Susan reduce stress?

Diagnostic Criteria

Panic disorder is a chronic condition that has several exacerbations and remissions during the course of the disease. The disabling panic attacks often lead to other symptoms, such as phobias.

Other diagnostic symptoms include palpitations, sweating, shaking, shortness of breath or smothering, sensations of choking, chest pain, nausea or abdominal distress, dizziness, derealization or depersonalization, fear of going crazy, fear of dying, paresthesias, and chills or hot flashes (APA, 2022) (see Key Diagnostic Characteristics 18.1).

Disorder Across the Lifespan

Children

Panic disorder is more likely to occur in adolescents than in younger children. It is estimated that panic disorder is

KEY DIAGNOSTIC CHARACTERISTICS 18.1 • PANIC DISORDER

Diagnostic Criteria

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:
Note: The abrupt surge can occur from a calm state or an anxious state.
   1. Palpitations, pounding heart, or accelerated heart rate
   2. Sweating
   3. Trembling or shaking
   4. Sensations of shortness of breath or smothering
   5. Feelings of choking
   6. Chest pain or discomfort
   7. Nausea or abdominal distress
   8. Feeling dizzy, unsteady, lightheaded, or faint
   9. Chills or heat sensations
   10. Paresthesias (numbness or tingling sensations)
   11. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
   12. Fear of losing control or "going crazy"
   13. Fear of dying
   Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming, or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
   1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy")
   2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)

C. The disturbance is not attributable to the physiologic effects of a substance (e.g., a drug or substance use disorder, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders)

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive–compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

experienced by 1% of adolescents aged 15 to 19. Children and adolescents with panic disorder are most likely experiencing another anxiety or mood disorder. Panic disorder has a significant impact on social and academic functioning and normal development (Baker & Waite, 2020).

Older Adults

Panic disorder occurs in the older adult, but it is an understudied disorder. It is unclear whether the disorder was present, but undiagnosed in early or middle adulthood or had its onset in the later years. In the older adult, panic disorder is associated with significant functional impairment, which compounds any functional issues associated with other comorbid disorders such as dementia (Pace et al., 2020).

Epidemiology and Risk Factors

Panic disorder has a moderately high lifetime prevalence in the general population with 1% to 2% 1-year prevalence rate and 2% to 4% lifetime rate (Forstner et al., 2021). Increased risk is associated with being female, middle aged, of low socioeconomic status, and widowed, separated, or divorced. The estimates of isolated panic attacks may affect 22.7% of the population. Panic disorders occur in several cultures, but the panic symptoms may be experienced differently across racial/ethnic groups (Coman et al., 2018).

Family history, alcohol use disorder and substance and stimulant use disorder, smoking tobacco, and severe stressors are risk factors for panic disorder. People who have several anxiety symptoms and those who experience separation anxiety during childhood often develop panic disorder later in life. Early-life traumas and adverse events, self-stigma, a history of physical or sexual abuse, socioeconomic or personal disadvantages, and behavioral inhibition have also been associated with an increased risk for anxiety disorders in children (Bourdon et al., 2019; Kolek et al., 2019).

Comorbidity

Patients may experience other anxiety disorders, depression, eating disorder, substance use disorder, or schizophrenia (Barbuti et al., 2021; Meuret et al., 2020). Although people with panic disorder are thought to have more somatic complaints than the general population, panic disorder does correlate with some medical conditions,

including vertigo, cardiac disease, gastrointestinal disorders, asthma, and those related to cigarette smoking.

The serious consequences of a respiratory infection by the COVID-19 contributes to anxiety and panic in individuals with asthma and respiratory illnesses (Javelot & Weiner, 2021). Health care workers are particularly vulnerable to mental health challenges including anxiety and depression during the pandemic (Mattila et al., 2021).

Etiology

Biologic Theories

There appears to be a substantial familial predisposition to panic disorder with an estimated heritability of 48% (Forstner et al., 2021). Studies show brain abnormalities in the "fear network" (amygdala, hippocampus, thalamus, midbrain, pons, medulla, and cerebellum) and changes in volume in different brain areas (Asok et al., 2019).

Serotonin and Norepinephrine

Serotonin and norepinephrine are both implicated in panic disorders. Norepinephrine effects act on those systems most affected by a panic attack—the cardiovascular, respiratory, and gastrointestinal systems. Serotonergic neurons are distributed in central autonomic and emotional motor control systems regulating anxiety states and anxiety-related physiologic and behavioral responses (Hornboll et al., 2018).

Gamma-Aminobutyric Acid

Gamma-aminobutyric acid (GABA) is the most abundant inhibitory neurotransmitter in the brain. GABA receptor stimulation causes several effects, including neurocognitive effects, reduction of anxiety, and sedation. GABA stimulation also results in increased seizure threshold. Abnormalities in the benzodiazepine–GABA–chloride ion channel complex have been implicated in panic disorder (Asok et al., 2019).

Hypothalamic–Pituitary–Adrenal Axis

Research implicates a role of the hypothalamic–pituitary–adrenal axis in panic disorders (Vinkers et al., 2021). A current explanation is that as stress hormones are activated, anxiety increases, which can lead to a panic attack. See Chapter 13.

Psychosocial Theories

Psychoanalytic and Psychodynamic Theories

Psychodynamic theories examine anxiety that develops after separation and loss. Many patients link their initial panic attacks with recent personal losses. However, the empirical evidence remains inadequate for a psychodynamic explanation. It remains unclear why some patients develop panic disorder, whereas others with similar experiences develop other disorders (Cackovic et al., 2020).

Cognitive-Behavioral Theories

Learning theory underlies most cognitive-behavioral explanations of panic disorder. Classic conditioning theory suggests that one learns a fear response by linking an adverse or fear-provoking event, such as a car accident, with a previously neutral event, such as crossing a bridge. One becomes conditioned to associate fear with crossing a bridge. Applying this theory to people with panic disorder has limitations. Phobic avoidance is not always developed secondary to an adverse event.

Further development of this theory led to an understanding of **interoceptive conditioning**, an association between physical discomforts, such as dizziness or palpitations, and an impending panic attack. For example, during a car accident, the individual may experience rapid heartbeat, dizziness, shortness of breath, and panic. Subsequent experiences of dizziness or palpitations, unrelated to an anxiety-provoking situation, incite anxiety and panic. Furthermore, people with panic disorder may misinterpret mild physical sensations (e.g., sweating, dizziness) as being catastrophic, causing panic as a result of learned fear (catastrophic interpretation). Some researchers hypothesize that individuals with a low sense of control over their environment or with a particular sensitivity to anxiety are vulnerable to misinterpreting normal stress. Controlled exposure to anxiety-provoking situations and cognitive countering techniques has proven successful in reducing the symptoms of panic.

Family Response to Disorder

Persons with a panic disorder may inadvertently cause excessive fears, phobias, or excessive worry in other family members. Families may limit social functions to prevent a panic attack. Those affected need a tremendous amount of support and encouragement from significant others.

RECOVERY-ORIENTED CARE FOR PERSONS WITH PANIC DISORDER

Teamwork and Collaboration: Working Toward Recovery

Nurses are pivotal in providing a safe and therapeutic inpatient environment and teaching patients strategies

for managing anxiety and fears. The nurse also administers prescribed medication, monitors its effects, and provides medication education. Advanced practice nurses, licensed clinical social workers, or licensed counselors provide individual psychotherapy sessions as needed. Often, a clinical psychologist gives psychological tests and interprets the results to assist in diagnosing and treating the panic disorder.

Panic Control Treatment

Panic control treatment involves intentional exposure (through exercise) to panic-invoking sensations such as dizziness, hyperventilation, tightness in the chest, and sweating. Identified patterns become targets for treatment. Patients are taught to use breathing training and cognitive restructuring to manage their responses and are instructed to practice these techniques between therapy sessions to adapt the skills to other situations.

Systematic Desensitization

Systematic desensitization, another exposure method used to desensitize patients, exposes the patient to a hierarchy of feared situations that the patient has rated from least to most feared. The patient is taught to use muscle relaxation as levels of anxiety increase through multisituational exposure. Planning and implementing exposure therapy require special training. Because of the multitude of outpatients in the treatment for panic disorder and agoraphobia (discussed later in chapter), exposure therapy is a useful tool for home health psychiatric nurses. Outcomes of home-based exposure treatment are similar to clinic-based treatment outcomes.

Implosive Therapy

Implosive therapy is a provocative technique useful in treating panic disorder and agoraphobia in which the therapist identifies phobic stimuli for the patient and then presents highly anxiety-provoking imagery to the patient, describing the feared scene as dramatically and vividly as possible. **Flooding** is a technique used to desensitize the patient to the fear associated with a particular anxiety-provoking stimulus. Desensitizing is done by presenting feared objects or situations repeatedly without session breaks until the anxiety dissipates. For example, a patient with ophidiophobia (i.e., a morbid fear of snakes) might be presented with a real snake repeatedly until the patient's anxiety decreases.

Exposure Therapy

Many of the treatment approaches used for panic disorder are effective for phobias (discussed in later chapters). **Exposure therapy** is the treatment of choice for phobias. The patient is repeatedly exposed to real or simulated anxiety-provoking situations until they become desensitized and anxiety subsides.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a highly effective tool for treating individuals with panic disorder. It is considered a first-line treatment for those with panic and other anxiety disorders and is often used in conjunction with medications, including selective serotonin reuptake inhibitors (SSRIs) (Bilet et al., 2020). The goals of CBT include helping the patient to manage their anxiety and correcting anxiety-provoking thoughts through interventions, including cognitive restructuring, breathing training, and psychoeducation.

Safety Issues

Panic attack symptoms mimic a heart attack—chest pain, palpitations, dyspnea. It is important to rule out any cardiac problems prior to diagnosing and treating a panic attack. Research shows that persons with panic disorder have higher oxidative stress due to impaired serotonin metabolism, which is related to heart disease (Aghayan et al., 2020).

Panic disorder is associated with an increased risk of suicide. A 3-year prevalence of suicide attempt in a sample of adults with panic disorder is 4.6%. Factors that independently predicted suicide attempts include psychopathology, prior history of suicide attempts, lower physical health-related quality of life, and greater number of stressful life events in the past year (Scheer et al., 2020).

EVIDENCE-BASED NURSING CARE OF PERSONS WITH PANIC DISORDER

Individuals often first seek help in the emergency department for their physical symptoms, but they are told that there are no life-threatening cardiac or neurologic causes for the severe physical symptoms. Although no laboratory tests exist to confirm anxiety disorders, a careful clinical assessment will reveal the presence of an anxiety disorder. Nursing Care Plan 18.1—which sets forth a plan of care for Doug, the case study patient in this chapter—is available at http://thepoint.lww.com/BoydEssentials3e.

Mental Health Nursing Assessment

A comprehensive nursing assessment includes overall physical and mental status, suicidal tendencies and thoughts, cognitive thought patterns, avoidance behavior

patterns, and family and cultural factors. Patients can be encouraged to keep a daily log of the severity of anxiety and the frequency, duration, and severity of panic episodes. This log will be a basic tool for monitoring progress as symptoms decrease.

Panic Attack Assessment

The assessment of the person with a panic disorder focuses on identifying the characteristics of the panic attack and the individual's strengths and problems. If the panic attack occurs in the presence of the nurse, direct assessment of the symptoms should be made and documented. Questions to ask the patient might include the following:

- What were you doing when the panic attack occurred?
- What did you experience before and during the panic episode, including physical symptoms, feelings, and thoughts?
- When did you begin to feel that way? How long did it last?
- Do you have an explanation for what caused you to feel and think that way?
- Have you experienced these symptoms in the past? If so, under what circumstances?
- Has anyone in your family ever had similar experiences?
- What do you do when you have these experiences to help you to feel safe?
- Have the feelings and sensations ever gone away on their own?

Physical Health

Key assessment areas of physical health that could have precipitated the panic attack include sleep patterns, activity levels, and health conditions.

Sleep Patterns and Physical Activity

Sleep is often disturbed in patients with panic disorder. In fact, panic attacks can occur during sleep, so the patient may fear sleep for this reason. Nurses should closely assess the impact of sleep disturbance because fatigue may increase anxiety and susceptibility to panic attacks. Panic disorder can be improved through active participation in a routine exercise program. If the patient does not exercise routinely, define the barriers to it. If exercise is avoided because of chronic muscle tension, poor muscle tone, muscle cramps, general fatigue, exhaustion, or shortness of breath, the symptoms may indicate poor physical health.

Nutrition

A nutritional assessment is important because people with panic disorder have increased rates of eating disorder behavior when compared to individuals without panic disorder (Garcia et al., 2020). The assessment is especially in women who are more likely to have a comorbid eating disorder than men. The nurse should inquire about the food and drink intake on a typical day and also include questions about binge or fasting behavior.

Medication

Several medications can cause anxiety. Bronchodilators, oral contraceptives, amphetamines (i.e., methylphenidate), steroids, thyroid medication, and several other medications can increase anxiety. In addition, medicines that contain caffeine, such as some pain and antiinflammatory agents, decongestants (i.e., phenylephrine), and some illegal drugs (cocaine), also increase anxiety.

Substance Use

Caffeine, pseudoephedrine, amphetamines, cocaine, or other stimulants are associated with panic disorder and may stimulate a panic attack. Tobacco use can also contribute to the risk for panic symptoms. Many individuals with panic disorder use alcohol or central nervous system (CNS) depressants in an effort to self-medicate anxiety symptoms; withdrawal from CNS depressants may produce symptoms of panic.

Other Physical Assessment Areas

Recent changes in physical status should be assessed. For example, pregnant patients should be assessed carefully for an underlying panic disorder. Although pregnancy may actually protect the mother from developing panic symptoms, postpartum onset of panic disorder requires particular attention. During a time that tremendous effort is spent on family, postpartum onset of panic disorder negatively affects lifestyle and decreases self-esteem in affected women, leading to feelings of overwhelming personal disappointment.

Psychosocial Assessment

A psychosocial assessment includes the patient's report of the symptoms and a careful cognitive, behavioral, and social assessment. The assessment should include the following behavioral responses, self-concept, stress and coping patterns, social network, functional status, and support systems. See Chapter 10.

Self-Report Scales

Self-evaluation is difficult in panic disorder. Often the memories of the attack and its triggers are irretrievable.

BOX 18.3

Rating Scales for Assessment of Panic Disorder and Anxiety Disorders

PANIC SYMPTOMS

Panic-Associated Symptom Scale (PASS)
Argyle, N., Delito, J., Allerup, P., Maier, W., Albus, M., Nutzinger, D., Rasmussen, S., Ayuso, J. L., & Bech, P. (1991). The Panic-Associated Symptom Scale: Measuring the severity of panic disorder. *Acta Psychiatrica Scandinavica*, *83*(1), 20–26.

Acute Panic Inventory
Dillon, D. J., Gorman, J. M., Liebowitz, M. R., Fyer, A. J., & Klein, D. F. (1987). Measurement of lactate-induced panic and anxiety. *Psychiatry Research*, *20*(2), 97–105.

National Institute of Mental Health Panic Questionnaire (NIMH PQ)
Scupi, B. S., Maser, J. D., & Uhde, T. W. (1992). The National Institute of Mental Health Panic Questionnaire: An instrument for assessing clinical characteristics of panic disorder. *Journal of Nervous and Mental Disease*, *180*(9), 566–572.

COGNITIONS

Anxiety Sensitivity Index
Reiss, S., Peterson, R. A., Gursky, D. M., & McNally, R. J. (1986). Anxiety sensitivity, anxiety frequency, and the prediction of fearfulness. *Behaviour Research and Therapy*, *24*(1), 1–8.

Agoraphobia Cognitions Questionnaire
Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. (1984). Assessment of fear in agoraphobics: The body sensations questionnaire and the agoraphobic cognitions questionnaire. *Journal of Consulting and Clinical Psychology*, *52*(6), 1090–1097.

Body Sensations Questionnaire
Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. (1984). Assessment of fear in agoraphobics: The body sensations questionnaire and the agoraphobic cognitions questionnaire. *Journal of Consulting and Clinical Psychology*, *52*(6), 1090–1097.

PHOBIAS

Mobility Inventory for Agoraphobia
Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E., & Williams, C. (1985). The mobility inventory for agoraphobia. *Behavior Research and Therapy*, *23*(1), 35–44.

Fear Questionnaire
Marks, I. M., & Matthews, A. M. (1979). Brief standard self-rating for phobic patients. *Behaviour Research and Therapy*, *17*(3), 263–267.

ANXIETY

State-Trait Anxiety Inventory (STAI)
Spielberger, C. D., Gorsuch, R. L., & Luchene, R. E. (1976). *Manual for the State-Trait Anxiety Inventory. Consulting Psychologists Press*.

Penn State Worry Questionnaire (PSWQ)
16 items developed to assess the trait of worry.
Meyer, T. J., Miller, M. L, Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, *28*(6), 487–495.

Beck Anxiety Inventory
21 items rating the severity of symptoms on a 4-point scale.
Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: The Beck Anxiety Inventory. *Journal of Consulting and Clinical Psychology*, *56*(6), 893–897.

Several tools are available to characterize and rate the patient's state of anxiety. Examples of these symptom and behavioral rating scales are provided in Box 18.3. All of these tools are self-report measures and as such are limited by the individual's self-awareness and openness. However, the Hamilton Rating Scale for Anxiety, provided in Table 18.3, is an example of a scale rated by the clinician (Hamilton, 1959). This 14-item scale reflects both psychological and somatic aspects of anxiety.

Mental Status Examination

During a mental status examination, individuals with panic disorder may exhibit anxiety symptoms, including restlessness, irritability, poor concentration, and apprehensive behavior. Disorganized thinking, irrational fears, and a decreased ability to communicate often occur during a panic attack. Assess by direct questioning whether the patient is experiencing suicidal thoughts, especially if they are abusing substances or taking antidepressant medications.

Cognitive Thought Patterns

Catastrophic misinterpretations of trivial physical symptoms can trigger panic symptoms. After they have been identified, these thoughts should serve as a basis for individualizing patient education to counter such false beliefs. Table 18.4 presents a scale to assess catastrophic misinterpretations of the symptoms of panic.

Several studies have found that individuals who feel a sense of control have less severe panic attacks. Individuals who fear loss of control during a panic attack often make the following type of statements:

- "I feel trapped."
- "I'm afraid others will know or that I'll hurt someone."
- "I feel alone. I can't help myself."
- "I'm losing control."

These individuals also tend to show low self-esteem, feelings of helplessness, demoralization, and overwhelming fears of experiencing panic attacks. They may have difficulty with assertiveness or expressing their feelings.

Social Network

Marital and parental functioning can be adversely affected by panic disorder. During the assessment, the nurse should try to grasp the patient's understanding of how

TABLE 18.3 HAMILTON RATING SCALE FOR ANXIETY

Max Hamilton designed this scale to help clinicians gather information about anxiety states. The symptom inventory provides scaled information that classifies anxiety behavior and assists the clinician in targeting behaviors and achieving outcome measures. Provide a rating for each indicator based on the following scale:

0 = None
1 = Mild
2 = Moderate
3 = Severe
4 = Severe, grossly disabling

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

Reprinted with permission from Hamilton, M. (1959). The assessment of anxiety states by rating. *British Journal of Medical Psychology, 32*(1), 50–55.

panic disorder with or without severe avoidance behavior has affected their life, along with that of the family. Pertinent questions include the following:

- How has the disorder affected your family's social life?
- What limitations related to travel has the disorder placed on you or your family?
- What coping strategies have you used to manage symptoms?
- How has the disorder affected your family members or others?

Cultural Factors

Cultural competence calls for the understanding of cultural knowledge, cultural awareness, cultural assessment skills, and cultural practice. Therefore, cultural differences must be considered in the assessment of panic disorder. Different cultures interpret sensations, feelings, or understandings differently. For example, symptoms of anxiety might be seen as witchcraft or magic (APA, 2022). Several cultures do not have a word to describe *anxiety* or *anxious* and instead may use words or meanings to suggest physical complaints (Moitra et al., 2018). Many over-the-counter (OTC) herbal remedies contain substances that may induce panic by increasing the heart rate, basal metabolic rate, blood pressure, and sweating (see Chapter 11).

Strengths Assessment

During the assessment, the patient's strengths will emerge. For example, a patient may tell you that he does not drink alcohol or use tobacco. Another may relate that he would like to exercise. Still another patient has a supportive partner or family member. The nurse can support these positive behaviors.

TABLE 18.4 PANIC ATTACK COGNITIONS QUESTIONNAIRE

Rate each of the following thoughts according to the degree to which you believe each thought contributes to your panic attack.

1 = Not at all	3 = Quite a lot				
2 = Somewhat	4 = Very much				
I'm going to die.		1	2	3	4
I'm going insane.		1	2	3	4
I'm losing control.		1	2	3	4
This will never end.		1	2	3	4
I'm really scared.		1	2	3	4
I'm having a heart attack.		1	2	3	4
I'm going to pass out.		1	2	3	4
I don't know what people will think.		1	2	3	4
I won't be able to get out of here.		1	2	3	4
I don't understand what is happening to me.		1	2	3	4
People will think I am crazy.		1	2	3	4
I'll always be this way.		1	2	3	4
I am going to throw up.		1	2	3	4
I must have a brain tumor.		1	2	3	4
I'll choke to death.		1	2	3	4
I'm going to act foolish.		1	2	3	4
I'm going blind.		1	2	3	4
I'll hurt someone.		1	2	3	4
I'm going to have a stroke.		1	2	3	4
I'm going to scream.		1	2	3	4
I'm going to babble or talk funny.		1	2	3	4
I'll be paralyzed by fear.		1	2	3	4
Something is physically wrong with me.		1	2	3	4
I won't be able to breathe.		1	2	3	4
Something terrible will happen.		1	2	3	4
I'm going to make a scene.		1	2	3	4

Adapted from Clum, G. A. (1990). *Panic attack cognitions questionnaire. Coping with panic: A drug-free approach to dealing with anxiety attacks.*: Brooks/Cole. Reprinted with permission from Dr. George A. Clum.

CLINICAL JUDGMENT

Suicide prevention is the first priority when caring for a person with a panic disorder. People with panic disorder are often depressed and consequently are at high risk for suicide. Adolescents with panic disorder are at higher risk for suicidal thoughts or may attempt suicide more often than other adolescents. Panic symptoms in early adolescence predict high risk for late adolescent depression and suicide ideation (Barzilay et al., 2020).

Once the nurse establishes that there is no indication of a risk for suicide, the nurse assesses whether the individual may be depressed, lonely, and socially isolated. Panic attacks may be unpredictable, leading the person to be fearful of another attack. Self-esteem may be low as feelings of powerlessness emerge. The patient may be experiencing physical panic symptoms, such as dizziness and hyperventilation. Because the whole family is affected by one member's symptoms, the family's needs may need to be considered.

The patient's strengths should be considered in planning care. For example, the person may be motivated to gain more control through making lifestyle changes. There may be evidence of family support. Outcomes will depend upon the particular health care issue and the interventions that are agreed upon by the patient and nurse.

THERAPEUTIC RELATIONSHIP

The therapeutic relationship is a critical aspect of helping the person work toward recovery. These individuals may appear to be very nervous or anxious throughout the interaction. The nurse should help the patient relax and be comfortable with discussing fears and anxiety. A calm, understanding approach in a comfortable environment will help the person relax and be willing to engage in a therapeutic relationship.

MENTAL HEALTH NURSING INTERVENTIONS

Establishing Mental Health and Wellness Goals

The course of panic disorder culminates in phobic avoidance as the affected person attempts to avoid situations that increase panic. Even though identifying and avoiding anxiety-provoking situations are important during therapy, drastically changing lifestyle to avoid situations does not aid recovery. Goals and interventions that focus on developing a healthy lifestyle, supporting a sense of accomplishment and control, and reducing anxiety and panic are particularly helpful in reducing the number and severity of the attacks.

Physical Care

COVID-19 causes additional fear and anxiety in persons with panic disorder. Physical distancing may exacerbate feeling of seclusion and lead to detrimental prolonged health effects. Quarantine and social isolation can easily prevent an individual with panic disorder from following up with medical issues, such as changes in cardiac functioning. Fears of being infected may prevent the person from picking up regular medications from the local pharmacy or grocery shopping (Pera, 2020).

Psychiatric mental health nurses who make home visits often provide the person with both medical and mental health care. Nurses should consider providing care that is usually given by other nurses.

Teaching Breathing Control

Hyperventilation is common. Often, people are unaware that they take rapid shallow breaths when they become anxious.

Teaching patients breathing control can be helpful. Focus on the breathing and help them to identify the rate, pattern, and depth. If the breathing is rapid and shallow, reassure the patient that exercise and breathing practice can help change this breathing pattern. Then, assist the patient in practicing abdominal breathing by performing the following exercises:

- Instruct the patient to breathe deeply by inhaling slowly through the nose. Have them place a hand on the abdomen just beneath the rib cage.
- Instruct the patient to observe that when one is breathing deeply, the hand on the abdomen will actually rise.
- After the patient understands this process, ask them to inhale slowly through the nose while counting to five, pause, and then exhale slowly through pursed lips.
- While the patient exhales, direct attention to feeling the muscles relax, focusing on "letting go."
- Have the patient repeat the deep abdominal breathing for 10 breaths, pausing between each inhalation and exhalation. Count slowly. If the patient complains of lightheadedness, reassure them that this is a normal feeling while deep breathing. Instruct the patient to stop for 30 seconds, breathe normally, and then start again.
- The patient should stop between each cycle of 10 breaths and monitor normal breathing for 30 seconds.
- This series of 10 slow abdominal breaths followed by 30 seconds of normal breathing should be repeated for 3 to 5 minutes.
- Help the patient to establish a time for daily practice of abdominal breathing.
- Abdominal breathing may also be used to interrupt an episode of panic as it begins. After patients have learned to identify their own early signs of panic, they can learn the four-square method of breathing, which helps divert or decrease the severity of the attack. Patients should be instructed as follows:
  - Advise the patient to practice during calm periods and to begin by inhaling slowly through the nose, count to four, and then hold the breath for a count of four.
  - Direct the patient to exhale slowly through pursed lips to a count of four and then rest for a count of four (no breath).
  - Finally, the patient may take two normal breaths and repeat the sequence.
  - After patients practice the skill, the nurse should assist them in identifying the physical cues that will alert them to use this calming technique.

Teaching Nutritional Planning

Maintaining regular and balanced eating habits reduces the likelihood of hypoglycemic episodes, lightheadedness, and fatigue. To help teach the patient about healthful eating and ways to minimize physical factors contributing to anxiety:

- Advise the patient to reduce or eliminate substances in the diet that promote anxiety and panic, such as food coloring, monosodium glutamate, and caffeine (withdrawal from which may stimulate panic). Patients need to plan to reduce caffeine consumption and then eliminate it from their diet. Many OTC remedies are now used to boost energy or increase mental performance; some of these contain caffeine. A thorough assessment should be made of all OTC products used to assess the potential of anxiety-provoking ingredients.
- Instruct the patient to check each substance consumed and note whether symptoms of anxiety occur and whether the symptoms are relieved by not consuming the product.

BOX 18.4

Teaching Progressive Muscle Relaxation

Choose a quiet, comfortable location where you will not be disturbed for 20 to 30 minutes. Your position may be lying or sitting, but all parts of your body should be supported, including your head. Wear loose clothing, taking off restrictive items, such as glasses and shoes.

Begin by closing your eyes and clearing your mind. Moving from head to toe, focus on each part of your body and assess the level of tension. Visualize each group of muscles as heavy and relaxed.

Take two or three slow abdominal breaths, pausing briefly between each breath. Imagine the tension flowing from your body.

Each muscle group listed subsequently should be tightened (or tensed isometrically) for 5 to 10 seconds and then abruptly released; visualize this group of muscles as heavy, limp, and relaxed for 15 to 20 seconds before tightening the next group of muscles. There are several methods to tighten each muscle group, and suggestions are provided subsequently. Each muscle group may be tightened two to three times until relaxed. Do not overtighten or strain. You should not experience pain.

- Hands: tighten by making fists
- Biceps: tighten by drawing forearms up and "making a muscle"
- Triceps: extend forearms straight, locking elbows
- Face: grimace, tightly shutting mouth and eyes
- Face: open mouth wide and raise eyebrows
- Neck: pull head forward to chest and tighten neck muscles
- Shoulders: raise shoulders toward ears
- Shoulders: push shoulders back as if touching them together
- Chest: take a deep breath and hold for 10 seconds
- Stomach: suck in your abdominal muscles
- Buttocks: pull buttocks together
- Thighs: straighten legs and squeeze muscles in thighs and hips
- Calves: pull toes carefully toward you, avoid cramps
- Feet: curl toes downward and point toes away from your body

Finally, repeat several deep abdominal breaths and mentally check your body for tension. Rest comfortably for several minutes, breathing normally, and visualize your body as warm and relaxed. Get up slowly when you are finished.

Teaching Relaxation Techniques

Teaching the patient relaxation techniques is another way to help individuals with panic and anxiety disorders. Some are unaware of the tension in their bodies and first need to learn to monitor their own tension. Isometric exercises and progressive muscle relaxation are helpful methods to learn to differentiate muscle tension from muscle relaxation. This method of relaxation is also useful when patients have difficulty clearing the mind, focusing, or visualizing a scene, which are often required in other forms of relaxation, such as meditation. Box 18.4 provides one method of progressive muscle relaxation.

Promoting Increased Physical Activity

Physical exercise can effectively decrease the occurrence of panic attacks by reducing muscle tension, increasing metabolism, increasing serotonin levels, and relieving stress. Exercise programs reduce many of the precipitants of anxiety by improving circulation, digestion, endorphin stimulation, and tissue oxygenation. In addition, exercise lowers cholesterol levels, blood pressure, and weight. After assessing for contraindications to physical exercise, assist the patient in establishing a routine exercise program. Engaging in 10- to 20-minute sessions on treadmills or stationary bicycles two to three times weekly is ideal during the winter months. Casual walking or bike riding during warmer weather promotes health. Help the patient to identify community resources that promote exercise.

Wellness Challenges

Many of the strategies that promote wellness are the same as those used to treat anxiety. For the person who is anxious or fearful, the individual may be more comfortable with a gradual incorporation of the strategies. Many wellness strategies for the person who is anxious should focus on physical health. See Box 18.5.

Medication Interventions

Some antidepressants (e.g., SSRIs and serotonin–norepinephrine reuptake inhibitors [SNRIs]) and antianxiety

BOX 18.5

Wellness Challenges for the Person With Anxiety

WELLNESS CHALLENGES

- Coping effectively with daily stresses without excessive worry
  - Strategies: Develop a daily schedule, allow time to relax, avoid trying to multitask, deep breathing, mindfulness
- Satisfying and enriching work
  - Strategies: Choose activities that are consistent with your skills and knowledge, consider other possibilities if job is too stressful.
- Incorporate physical activity, healthy foods, and adequate sleep into daily life
  - Strategies: Schedule regular physical activity, make a weekly menu of healthy meals, establish healthy sleep hygiene routines
- Developing a sense of connection, belong, and a support system
  - Strategies: Join a support group, seek out recreational activities with friends and families
- Expanding a sense of purpose and meaning in life
  - Strategies: Focus on goals, values, and beliefs, read inspiring stories or essays

TABLE 18.5 MEDICATION FOR PANIC DISORDER

Medication	Starting Dose (mg/day)	Therapeutic Dose	Side Effects
SSRIs			Class effects: nausea, anorexia, tremors, anxiety, sexual dysfunction, jitteriness, insomnia, suicidality
Fluoxetine (Prozac)	10	20–60	Class effects
Sertraline (Zoloft)	25	50–200	Class effects, loose stools
Paroxetine (Paxil)	10	10–60	Class effects, drowsiness, fatigue
Paroxetine (controlled release) (Paxil CR)	12.5	12.5–75	Class effects
SNRIs			Class effects: nausea, sweating, dry mouth, dizziness, insomnia, somnolence, sexual dysfunction, hypertension
Venlafaxine (extended release)	37.5	75–300	Class effects
Benzodiazepines			Class effects: sedation, cognitive slowing, physical dependence
Clonazepam (Klonopin)	0.25 TID	0.5–2.0 BID	Class effects
Alprazolam (Xanax)	0.25 TID	0.5–1.5 TID	Class effects

BID, two times a day; SNRIs, serotonin–norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; TID, three times a day.

medication (e.g., benzodiazepines) are U.S. Food and Drug Administration, approved for treating people with panic disorders (see Table 18.5).

Selective Serotonin Reuptake Inhibitors

The SSRIs are recommended as the first drug option in the treatment of patients with panic disorder. They have the best safety profile, and if side effects occur, they tend to be present early in treatment before the therapeutic effect takes place. Hence, the SSRIs should be started at low doses and titrated every 5 to 7 days. Antidepressant therapy is recommended for long-term treatment of the disorder and antianxiety as adjunctive treatment (Zugliani et al., 2019). The SSRIs produce anxiolytic effects by increasing the transmission of serotonin by blocking serotonin reuptake at the presynaptic cleft. The initial increase in serotonergic activity with SSRIs may cause temporary increases in panic symptoms and even panic attacks. After 4 to 6 weeks of treatment, anxiety subsides, and the antianxiety effect of the medications begins (see Chapter 11). Increased serotonin activity in the brain is believed to decrease norepinephrine activity. This decrease lessens cardiovascular symptoms of tachycardia and increased blood pressure, which are associated with panic attacks. See Chapter 21 for administration and monitoring side effects.

NCLEXNOTE Psychopharmacologic treatment is almost always needed. Antidepressants are the medications of choice. Antianxiety medication is used only for short periods of time.

Serotonin–Norepinephrine Reuptake Inhibitors

The SNRIs increase levels of both serotonin and norepinephrine by blocking their reuptake presynaptically. Classified as antidepressants, the SNRIs are also used in anxiety disorders. Venlafaxine is the most commonly used SNRI (see Table 18.4). These medications have been shown to reduce the severity of panic and anticipatory anxiety. Similar to the SSRIs, they should not be abruptly discontinued (see Chapter 11).

Benzodiazepine Therapy

The high-potency benzodiazepines have produced antipanic effects; their therapeutic onset is much faster than that of antidepressants (see Table 18.4). Therefore, benzodiazepines are tremendously useful in treating intensely distressed patients. Alprazolam (Xanax), lorazepam (Ativan), and clonazepam (Klonopin) are widely used for panic disorder. They are well tolerated but carry the risk for withdrawal symptoms upon discontinuation of use (see Box 18.6). The benzodiazepines are still commonly used for panic disorder even though the SSRIs are recommended for first-line treatment of panic disorder (Du et al., 2021).

Administering and Monitoring Benzodiazepines

Treatment may include administering benzodiazepines concurrently with antidepressants for the first 4 weeks and then tapering the benzodiazepine to a maintenance dose. This strategy provides rapid symptom relief but avoids the complications of long-term benzodiazepine use. Benzodiazepines with short half-lives do not accumulate in the body, but benzodiazepines with half-lives of longer than 24 hours tend to accumulate with long-term treatment, are removed more slowly, and produce less intense symptoms on discontinuation of use (see Chapter 11).

BOX 18.6

Drug Profile: Alprazolam (Xanax)

DRUG CLASS: Antianxiety agent

RECEPTOR AFFINITY: Exact mechanism of action is unknown; believed to increase the effects of γ-aminobutyrate.

INDICATIONS: Management of anxiety disorders, short-term relief of anxiety symptoms or depression-related anxiety, panic attacks with or without agoraphobia.

ROUTES AND DOSAGES: Available in 0.25-, 0.5-, 1-, and 2-mg scored tablets.

Adults: For anxiety: Initially, 0.25 to 0.5 mg PO TID titrated to a maximum daily dose of 4 mg in divided doses. For panic disorder: Initially, 0.5 mg PO TID increased at 3- to 4-day intervals in increments of no more than 1 mg/day.

Geriatric Patients: Initially, 0.25 mg BID to TID, increased gradually as needed and tolerated.

HALF-LIFE (PEAK EFFECT): 12 to 15 hours (1 to 2 hours).

SELECTED ADVERSE REACTIONS: Transient mild drowsiness, initially; sedation, depression, lethargy, apathy, fatigue, lightheadedness, disorientation, anger, hostility, restlessness, headache, confusion, crying, constipation, diarrhea, dry mouth, nausea, and possible drug dependence.

WARNINGS: Contraindicated in patients with psychosis, acute narrow-angle glaucoma, shock, acute alcoholic intoxication with depressed vital signs, pregnancy, labor and delivery, and breastfeeding. Use cautiously in patients with impaired hepatic or renal function and severe debilitating conditions. Risk for digitalis toxicity if given concurrently with digoxin. Increased CNS depression if taken with alcohol, other CNS depressants, and propoxyphene (Darvon).

SPECIFIC PATIENT AND FAMILY EDUCATION

- Avoid using alcohol, sleep-inducing drugs, and other OTC drugs.
- Take the drug exactly as prescribed, and do not stop taking the drug without consulting your primary health care provider.
- Take the drug with food if gastrointestinal upset occurs.
- Avoid driving a car or performing tasks that require alertness if drowsiness or dizziness occurs.
- Report any signs and symptoms of adverse reactions.
- Notify your primary health care provider if severe dizziness, weakness, or drowsiness persists or if rash or skin lesions, difficulty voiding, palpitations, or swelling of the extremities occurs.

BID, two times a day; CNS, central nervous system; OTC, over-the-counter; PO, oral; TID, three times a day.

Short-acting benzodiazepines, such as alprazolam, are associated with rebound anxiety, or anxiety that increases after the peak effects of the medication have decreased. Medications with short half-lives (alprazolam, lorazepam) should be given in three or four doses spaced throughout the day, with a higher dose at bedtime to allay anxiety-related insomnia. Clonazepam, a longer-acting benzodiazepine, requires less frequent dosing and has a lower risk for rebound anxiety.

Because of their depressive CNS effects, benzodiazepines should not be used to treat patients with comorbid sleep apnea. In fact, these drugs may actually decrease the rate and depth of respirations. Exercise caution in older adult patients for these reasons. Discontinuing medication use requires a slow taper during a period of several weeks to avoid rebound anxiety and serious withdrawal symptoms. Benzodiazepines are not indicated in the chronic treatment of patients with substance use disorder but can be useful in quickly treating anxiety symptoms until other medications take effect.

Symptoms associated with withdrawal of benzodiazepine therapy are more likely to occur after high doses and long-term therapy. They can also occur after short-term therapy. Withdrawal symptoms manifest in several ways, including psychological (e.g., apprehension, irritability, agitation).

Monitoring Side Effects

SSRIs should not be given with monoamine oxidase inhibitors (MAOIs) because of potential drug interaction. Drugs that interact with benzodiazepines include the tricyclic antidepressants (TCAs) and digoxin; interaction may result in increased serum TCA or digoxin levels. Alcohol and other CNS depressants, when used with benzodiazepines, increase CNS depression. Their concomitant use is contraindicated. Histamine-2 blockers (e.g., cimetidine) used with benzodiazepines may potentiate sedative effects. Monitor closely for effectiveness in patients who smoke; cigarette smoking may increase the clearance of benzodiazepines.

Management of Complications

The side effects of benzodiazepine medications generally include headache, confusion, dizziness, disorientation, sedation, and visual disturbances. Sedation should be monitored after beginning medication use or increasing the dose. The patient should avoid operating heavy machinery until the sedative effects are known.

Concurrent use of SSRIs and the MAOIs is contraindicated. These antidepressants should not be given together.

Teaching Points

Warn patients to avoid alcohol because of the chance of CNS depression. In addition, warn them not to operate heavy machinery until the sedative effects of the medication are known.

Psychosocial Interventions

Therapeutic Interactions

Peplau (1989) devised general guidelines for nursing interventions that might be successful in treating patients with anxiety. These interventions help the

TABLE 18.6 NURSING INTERVENTIONS BASED ON DEGREES OF ANXIETY

Degree of Anxiety	Nursing Interventions
Mild	Assist patient to use the energy anxiety provides to encourage learning.
Moderate	Encourage patient to talk: to focus on one experience, to describe it fully, and then to formulate the patient's generalizations about that experience.
Severe	Allow relief behaviors to be used but do not ask about them. Encourage the patient to talk: ventilation of random ideas is likely to reduce anxiety to a moderate level.
Panic	Stay with the patient. Allow pacing and walk with the patient. No content inputs to the patient's thinking should be made by the nurse. (They burden the patient, who will distort them.) Be direct with the fewest number of words: e.g., "Drink this" (give liquids to replace lost fluids and to relieve dry mouth); "Say what's happening to you," "Talk about yourself," or "Tell what you feel now" (to encourage ventilation and externalization of inner, frightening experience). Pick up on what the patient says, for example, Patient: "What's happening to me—how did I get here?" Nurse: "Say what you notice." Use short phrases to the point of the patient's comment. Do not touch the patient; patients experiencing panic are very concerned about survival, are experiencing a grave threat to self, and usually distort intentions of all invasions of their personal space.

Adapted from Peplau, H. (1989). Theoretical constructs: Anxiety, self, and hallucinations. In O'Toole, A., & Welt, S. (eds.) *Interpersonal theory in nursing practice: Selected works of Hildegarde E.* Springer.

patient attend to and react to input other than the subjective experience of anxiety. They are designed to help the patient focus on other stimuli and cope with anxiety in any form (Table 18.6). These general interventions apply to all anxiety disorders and therefore are not reiterated in subsequent sections.

Enhancing Cognitive Functioning

Distraction

After patients can identify the early symptoms of panic, they may learn to implement distraction behaviors that take the focus off the physical sensations. Some activities include initiating conversation with a nearby person or engaging in physical activity (e.g., walking, gardening, or housecleaning). Performing simple repetitive activities such as snapping a rubber band against the wrist, counting backward from 100 by 3s, or counting objects along the roadway might also deter an attack.

Reframing

Reframing is a cognitive technique that can change the way a situation, event, or person is viewed and reduce the impact of anxiety-provoking thoughts. People with anxiety disorders often view themselves negatively and use "should statements" and "negative labels." Should statements lead to rigid rules and unrealistic expectations? By encouraging patients to avoid the use of should statements and reframe their views, they can change their beliefs to be more realistic. For example, if a patient says, "I should be a better parent" or "I'm a useless failure," the nurse could ask the person to identify the positive aspects of parenting and other successes.

Consider This:

Could distraction and reframing help Doug reduce his anxiety and frequency of his panic attacks? What interventions would you recommend and why?

Positive Self-Talk

During states of increased anxiety and panic, individuals can learn to counter fearful or negative thoughts by using another cognitive approach. **Positive self-talk** involves planning and rehearsing positive coping statements "This is only anxiety, and it will pass," "I can handle these symptoms," and "I'll get through this" are examples of positive self-talk. These types of positive statements can give the individual a focal point and reduce fear when panic symptoms begin. Handheld cards that offer positive statements can be carried in a purse or wallet so the person can retrieve them quickly when panic symptoms are felt (Box 18.7).

NCLEXNOTE Cognitive interventions give patients with anxiety a sense of control over the recurring threats of panic and obsessions.

Psychoeducation

Psychoeducation programs help to teach patients and families about the symptoms of panic. Individuals with panic disorder legitimately fear going crazy, losing control, or dying because of their physical symptoms. Attempting to convince a patient that such fears are groundless only heightens anxiety and impedes communication. Information and physical evidence (e.g., electrocardiogram results, laboratory test results) should be presented in a caring and open manner that demonstrates acceptance and understanding of their situation.

BOX 18.7 • THERAPEUTIC DIALOGUE • Panic Disorder

Doug is admitted to an inpatient unit following another severe panic attack. He had an argument with his high school son, who continues to use alcohol and marijuana. Financial problems are also escalating.

INEFFECTIVE APPROACH

Nurse: Oh…. Why are you crying?

Doug: (Looks up, gives a nervous chuckle.) Obviously, because I'm upset. I am tired of living this way. I just want to be normal again. I can't even remember what that feels like.

Nurse: You look normal to me. Everyone has bad days. It'll pass.

Doug: I've felt this way longer than you've been alive. I've tried everything, and nothing works.

Nurse: You're not the first depressed person that I've taken care of. You just need to go to groups and stay out of your room more. You'll start feeling better.

Doug: (Angrily) Oh, it's just that easy. You have no idea what I'm going through! You don't know me! You're just a kid.

Nurse: I can help you if you help yourself. A group starts in 5 minutes, and I'd like to see you there.

Doug: I'm not going to no damn group! I want to be alone so I can think!

Nurse: (Looks about anxiously.) Maybe I should come back after you've calmed down a little.

EFFECTIVE APPROACH

Nurse: Doug, I noticed that you are staying in your room more today. What's troubling you?

Doug: (Looks up) I feel like I've lost complete control of my life. I'm so anxious, and nothing helps. I'm tired of it.

Nurse: I see. That must be difficult. Can you tell me more about what you are feeling right now?

Doug: I feel like I'm going crazy. I worry all the time about having panic attacks. They make me scared I'm going to die. Sometimes I think I'd be better off dead.

Nurse: (Remains silent, continues to give eye contact.)

Doug: Do you know what it's like to be a prisoner to your emotions? I can't even go to work sometimes, and when I do, it's terrifying. I don't know what to think anymore.

Nurse: Doug, you have lived with this disorder for a long time. You say that the medications do not work to your liking, but what has helped you in the past?

Doug: Well, I learned in relaxation group that panic symptoms are probably caused by chemicals in my brain that are not working correctly. I learned that medications can help, but they don't work well for me. I tried an exposure plan and relaxation techniques to deal with my fears of leaving the house and my chronic anxiety. That did help some, but it's scary to do.

Nurse: It sounds like you have learned a lot about your illness, one that can be treated, so that you don't always have to feel this way.

Doug: This is easier to say right now when I'm here and can get help if I need it. It's hard to remember this when I'm in the middle of a panic attack and think I'm dying.

Nurse: It's harder when you're alone?

Doug: Much harder! And I'm alone so much of the time.

Nurse: Let's talk about some ways you can manage your panics when you're alone. Tell me some of the techniques you've learned.

CRITICAL THINKING CHALLENGE

- What tone is established by the nurse's opening question in the first scenario?
- Which therapeutic communication techniques did the nurse use in the second scenario to avoid the pitfalls encountered in the first scenario?
- What information was uncovered in the second scenario that was not touched on in the first?
- What predictions can you make about the interpersonal relationship likely to develop between the nurse and the patient in each scenario?

BOX 18.8

Psychoeducation Checklist: Panic Disorder

When caring for a patient with panic disorder, be sure to include the following topic areas in the teaching plan:

- Psychopharmacologic agents (anxiolytics or antidepressants) if ordered, including drug action, dosage, frequency, and possible adverse effects
- Breathing control measures
- Nutrition
- Exercise
- Progressive muscle relaxation
- Distraction behaviors
- Exposure therapy
- Time management
- Positive coping strategies

Box 18.8 suggests topics for individual or small-group discussion. It is especially important to cover such topics as the differences between panic attacks and heart attacks, the difference between panic disorder and other psychiatric disorders, and the effectiveness of various treatment methods.

Wellness Strategies

Individuals with panic disorder, especially those with significant anxiety sensitivity, may need assistance in reevaluating their lifestyle. Time management can be a useful tool. In the workplace or at home, underestimating the time needed to complete a chore or being overly involved in several activities at once increases stress and anxiety. Procrastination, lack of assertiveness, and difficulties with prioritizing or delegating tasks intensify these problems.

Writing a list of chores to be completed and estimating time to complete them provide concrete feedback to the individual. Crossing out each activity as it is completed helps the patient to regain a sense of control and accomplishment. Large tasks should be broken into a series of smaller tasks to minimize stress and maximize sense of achievement. Rest, relaxation, and family time—frequently omitted from the daily schedule—must be included.

Providing Family Education

In addition to learning the symptoms of panic disorder, nurses should have information sheets or pamphlets available concerning the disorder and any medications prescribed. Parents, especially single parents, will need assistance in child-rearing and may benefit from services designed to provide some respite. Moreover, the entire family will need support in adjusting to the disorder. A referral for family therapy is indicated, because involving the entire family in the therapy process is imperative. Families experience the symptoms, treatments, clinical setbacks, and recovery from chronic mental illnesses as a unit. Misunderstandings, misconceptions, false information, and the stigma of mental illness, singly or collectively, impede recovery efforts.

Convening Support Groups

Participation in supportive groups is helpful in managing anxiety and fears (Barkowski et al., 2020). Persons with panic disorders are usually comfortable in groups with individuals who have other mental disorders and issues. As they participate in a group, they are able to share their fears of an impending panic attack and identify strategies to deal with their fears.

Developing Recovery-Oriented Rehabilitation Strategies

Recovery begins with an understanding of the components of recovery discussed in Chapters 1 and 7. As the components of recovery are explained, the nurse should continue to engage the person in a collaborative decision-making process. The nurse's role in developing recovery-oriented strategies is to negotiate the most effective, evidence-based strategies. The nurse should encourage healthy behaviors supporting wellness as well as strategies directed toward illness management. Empowering the person to make choices that best match the individual's lifestyle increases the likelihood of treatment adherence and recovery. It will also foster a feeling of hopefulness. Some treatment recommendations will not be followed. For example, some persons will attend support groups, but others only want individual psychotherapy. The nurse should encourage the patient to commit to as many recovery strategies that are realistic.

Evaluation and Treatment Outcomes

Although many researchers consider panic disorder a chronic, long-term condition, the positive results from outcome studies should be shared with patients to provide encouragement and optimism that patients can learn to manage these symptoms. Outcome studies have demonstrated success with panic control treatment, CBT therapy, exposure therapy, and various medications specific to certain symptoms.

Continuum of Care

Emergency Care

Because individuals with panic disorder are likely to first present for treatment in an emergency department or primary care setting, nurses working in these settings

should be involved in early recognition and referral. Consultation with a psychiatrist or mental health professional by the primary care physician can decrease both costs and overall patient symptoms. Several interventions may be useful in reducing the number of emergency department visits related to panic symptoms. Psychiatric consultation and nursing education can be provided in the emergency department to explore other avenues of treatment. Remembering that the patient experiencing a panic attack is in crisis, nurses can take several measures to help alleviate symptoms, including the following:

- Stay with the patient and maintain a calm demeanor. (Anxiety often produces more anxiety, and a calm presence will help calm the patient.)
- Reassure the patient that you will not leave, that this episode will pass, and that they are in a safe place. (The patient often fears dying and cannot see beyond the panic attack.)
- Give clear concise directions using short sentences. Do not use medical jargon.
- Walk or pace with the patient to an environment with minimal stimulation. (The patient in panic has excessive energy.)
- Administer PRN (i.e., as-needed) anxiolytic medications as ordered and appropriate. (Pharmacotherapy is effective in treating those patients with acute panic attack.)
- After the panic attack has resolved, allow the patient to vent their feelings. This often helps the patient in clarifying their feelings.

Inpatient-Focused Care

Inpatient settings provide control for the stabilization of the acute panic symptoms and initiation of recovery-oriented strategies. Medication use often is initiated here because patients who show initial panic symptoms require in-depth assessment to determine the cause. As recovery begins, crisis stabilization, medication management, milieu therapy, and psychotherapies are introduced, and outpatient discharge linkage appointments are set.

Community Care

Most individuals with panic disorder are treated on an outpatient basis. Referral lists of community resources and support groups are useful in this setting. A discussion about the recovery and the importance of the 10 components helps healing begin (see Chapters 1 and 7). Nurses are more directly involved in treatment, conducting psychoeducation groups on relaxation and breathing techniques, symptom management, and anger management. Advanced practice nurses conduct CBT and individual and family psychotherapy. In addition, medication monitoring groups reemphasize the role of medications, monitor for side effects, and enhance treatment compliance overall.

As with any disorder, a continuum of patient care across multiple settings is crucial. Patients are treated in the least restrictive environment that will meet their safety needs. As the patient progresses through treatment, the environment of care changes from an emergency or inpatient setting to outpatient clinics or individual therapy sessions.

Virtual Mental Health Care

Virtual mental health services are more important now because of the impact of the coronavirus pandemic. The pandemic increased anxieties, depression, and grief. Face-to-face therapies increase anxiety about the risk of infection in individuals who already have significant anxieties. Virtual treatment is ideal. Most therapies discussed in this chapter are available in a virtual format. The patient needs to be cautioned about selecting services that are credible. Support groups such as the National Alliance on Mental Illness and the Anxiety and Depression Association of America are easily accessed online and provide resources for clinicians and patients.

Integration With Primary Care

Coordination of care between mental health and primary care leads to safer management of anxiety disorders. Some groups are more likely to seek out care in primary care rather than in mental health clinics. People with anxiety disorders are often treated in the primary care environment, particularly those who experience panic disorder. Because panic attacks mimic cardiac difficulties, it is important that the patient continues to seek health care monitoring with medical clinicians. Primary care providers are often asked to treat the physical consequences of anxiety, such as hypertension and obesity (Penninx & Lange, 2018). Anxiety can be caused by physical health issues, such as immune, metabolic, and cardiovascular problems. Many prescription and nonprescription drugs can cause anxiety such as asthma, blood pressure, steroid, and thyroid medications. Without coordination of care, the clinicians will not be able to make a meaningful assessment, which could lead to the wrong treatment (Love & Love, 2019).

GENERALIZED ANXIETY DISORDER

Generally speaking, patients with generalized anxiety disorder (GAD) feel frustrated, disgusted with life, demoralized, and hopeless. They may state that they cannot remember a time that they did not feel anxious. They experience a sense of ill-being and uneasiness and a

fear of imminent disaster. Over time, they may recognize that their chronic tension and anxiety are unreasonable.

Clinical Course

The onset of GAD is insidious. Many patients complain of being chronic worriers. GAD affects individuals of all ages. About half of individuals with GAD report an onset in childhood or adolescence, although onset after 20 years of age is also common. Adults with GAD often worry about matters such as their job, household finances, health of family members, or simple matters (e.g., household chores or being late for appointments). The intensity of the worry fluctuates, and stress tends to intensify the worry and anxiety symptoms (APA, 2022).

Patients with GAD may exhibit mild depressive symptoms, such as dysphoria. They are also highly somatic, with complaints of multiple clusters of physical symptoms, including muscle aches, soreness, and gastrointestinal ailments. In addition to physical complaints, patients with GAD often experience poor sleep habits, irritability, trembling, twitching, poor concentration, and an exaggerated startle response. People with this disorder often are seen in a primary care setting with somatic symptoms (DeMartini et al., 2019).

Diagnostic Criteria

GAD is characterized by excessive worry and anxiety (apprehensive expectation) for at least 6 months. The anxiety does not usually pertain to a specific situation; rather, it concerns several real-life activities or events. Ultimately, excessive worry and anxiety cause great distress and interfere with the patient's daily personal or social life.

Nursing Care

Nursing care for the person with GAD is similar to the care of the individual with a panic disorder. In many instances, antidepressants and an antianxiety agent will be prescribed. Nursing interventions should focus on helping the person target specific areas of anxiety and reducing the impact of the anxiety. See Box 18.9.

BOX 18.9

Psychoeducation Checklist: Generalized Anxiety Disorder

When caring for the patient with GAD, be sure to include the following topic areas in the teaching plan:

- Psychopharmacologic agents (benzodiazepines, antidepressants, nonbenzodiazepine anxiolytics, β-blockers) if ordered, including drug action, dosage, frequency, and possible adverse effects
- Breathing control
- Nutrition and diet restriction
- Sleep measures
- Progressive muscle relaxation
- Time management
- Positive coping strategies

OTHER ANXIETY DISORDERS

Other disorders exist that have anxiety as their defining feature. These include generalized phobia, agoraphobia, specific phobias, and social anxiety disorder.

AGORAPHOBIA

Agoraphobia is fear or anxiety triggered by about two or more situations such as using public transportation, being in open spaces, being in enclosed places, standing in line, being in a crowd, or being outside of the home alone. When these situations occur, the individual believes that something terrible might happen and that escape may be difficult. The individual may experience panic like symptoms or other embarrassing symptoms (e.g., vomiting, diarrhea) (APA, 2022). Agoraphobia leads to avoidance behaviors. Such avoidance interferes with routine functioning and eventually renders the person afraid to leave the safety of home. Some affected individuals continue to face feared situations but with significant trepidation (i.e., going in public only to pay bills or to take children to school). Agoraphobia may occur with panic disorder but is considered a separate disorder.

SPECIFIC PHOBIA DISORDER

Specific phobia disorder is marked by persistent fear of clearly discernible, circumscribed objects or situations, which often leads to avoidance behaviors. Phobic objects can include animals (e.g., spiders, snakes), natural environment (e.g., heights, storms), blood injection injury (e.g., fear of blood, injections), and situational (e.g., elevators, enclosed spaces). The 12-month community prevalence estimate range from 8% to 12%, and the disorder generally affects women twice as much as men (APA, 2022). It has a bimodal distribution, peaking in childhood and then again in the 20s. The focus of the fear in specific phobia may result from the anticipation of being harmed by the phobic object. For example, dogs are feared because of the chance of being bitten or automobiles are feared because of the potential of crashing. The focus of fear may likewise be associated with concerns about losing control, panicking, or fainting on exposure to the phobic object.

Anxiety is usually felt immediately on exposure to the phobic object; the level of anxiety is usually related to both the proximity of the object and the degree to which escape is possible. For example, anxiety heightens

BOX 18.10

Common Phobias

- Acrophobia: fear of heights
- Agoraphobia: fear of open spaces
- Ailurophobia: fear of cats
- Algophobia: fear of pain
- Arachnophobia: fear of spiders
- Brontophobia: fear of thunder
- Claustrophobia: fear of closed spaces
- Cynophobia: fear of dogs
- Entomophobia: fear of insects
- Hematophobia: fear of blood
- Microphobia: fear of germs
- Nyctophobia: fear of night or dark places
- Ophidiophobia: fear of snakes
- Phonophobia: fear of loud noises
- Photophobia: fear of light
- Pyrophobia: fear of fire
- Tropophobia: fear of a place, like a stage
- Xenophobia: fear of strangers
- Zoophobia: fear of animal or animals

as a cat approaches a person who fears cats and lessens when the cat moves away. At times, the level of anxiety escalates to a full panic attack, particularly when the person must remain in a situation from which escape is deemed to be impossible. Fear of specific objects is fairly common, and the diagnosis of specific phobia is not made unless the fear significantly interferes with functioning or causes marked distress. Assessment differentiates simple phobia from other diagnoses with overlapping symptoms. Box 18.10 lists a number of specific phobias. Among adult patients who are seen in clinical settings, typical phobias are situational phobias, natural environment phobias, blood injection, injury phobia, and animal phobias (APA, 2022).

Blood injection injury phobia merits special consideration because the phobia involves medical treatments. The physiologic processes that are exhibited during phobic exposure include a strong vasovagal response, which significantly increases blood pressure and pulse, followed by deceleration of the pulse and lowering of blood pressure in the patient. Monitor closely when giving required injections or medical treatments.

About 75% of patients with blood injection injury phobia report fainting on exposure. Factors that may predispose individuals to specific phobias may include traumatic events; unexpected panic attacks in the presence of the phobic object or situation; observation of others experiencing a trauma; or repeated exposure to information warning of dangers, such as parents repeatedly warning young children that dogs bite.

Phobic content must be evaluated from an ethnic or cultural background. In some cultures, fears of spirits or magic are common. They should be considered part of a disorder only if the fear is excessive in the context of the culture, causes the individual significant distress, or impairs the ability to function. Psychotropic drugs have not been effective in the treatment of specific phobia. Anxiolytics may give short-term relief of phobic anxiety, but no evidence confirms that they affect the course of the disorder. The treatment of choice for specific phobia is exposure therapy. Patients who are highly motivated can experience success with treatment (Böhnlein et al., 2020).

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

Social anxiety disorder involves a persistent fear of social or performance situations in which embarrassment may occur. Exposure to a feared social or performance situation nearly always provokes immediate anxiety and may trigger panic attacks. People with social anxiety disorder fear that others will scrutinize their behavior and judge them negatively. They often do not speak up in crowds out of fear of embarrassment. They go to great lengths to avoid feared situations. If avoidance is not possible, they suffer through the situation with visible anxiety (APA, 2022).

People with social anxiety disorder appear to be highly sensitive to disapproval or criticism, tend to evaluate themselves negatively, and have poor self-esteem and a distorted view of their personal strengths and weaknesses. They may magnify their personal flaws and underrate any talents. They often believe others would act with more assertiveness in a given social situation. Women are more likely to have social anxiety disorder, but both men and women tend to have difficulties with dating and with sexual relationships (Asher et al., 2017). Children tend to underachieve in school because of test-taking anxiety. This is an important area that should be assessed in all patients. See Box 18.11.

Generalized social anxiety disorder is diagnosed when the individual experiences fears related to most social situations, including public performances and social interactions. These individuals are likely to demonstrate deficiencies in social skills, and their phobias interfere with their ability to function (Asher et al., 2017).

People with social anxiety disorder fear and avoid only one or two social situations. Classic examples of such situations are eating, writing, or speaking in public or using public bathrooms. The most common fears for individuals with social anxiety disorder are public speaking, fear of meeting strangers, eating in public, writing in public, using public restrooms, and being stared at or being the center of attention.

Pharmacotherapy is a relatively new area of research in treating patients with social anxiety disorder. SSRIs are used to treat those with social anxiety disorder because they significantly reduce social anxiety and phobic avoidance. Benzodiazepines are also used to reduce anxiety

BOX 18.11

Research for Best Practice: A Mental Health Recovery Journey

Hickmott, J., & Raeburn, T. (2020). Mouse to man, a mental health recovery journey. Journal of Psychiatric and Mental Health Nursing, 27(6), 844–849. https://doi.org/10.1111/jpm.12621

THE QUESTION: What are the insights that can be gained from narratives written by people with lived experience of mental illness?

METHODS: A lived experience about recovery from a social anxiety disorder that began in childhood is written in first person.

FINDINGS: Recovery is an ongoing process of growth and development. His symptoms began at age 11 years when his parents divorced and he began missing school, not communicating with teachers, and avoiding doctors. The author did not recognize that he needed help until after he attended a clinic at age 16 years. He experienced treatment in a variety of settings for social anxiety. He did not really engage in recovery until he began seeing a nurse who was more like a coach and he was the player. Within this collaborative relationship, he learned a lot about what was going on with him. He gained insight, finished university, and is now a Peer Worker.

IMPLICATIONS FOR NURSING: This narrative supports the need for recovery-oriented mental health nursing and the hypothesis that recovery is possible. Hope was important throughout his journey. Recovery takes time. In this instance, it was 2 years of frequent visits. This narrative emphasizes that individuals with mental health issues are more than symptoms. It is important to see the whole person.

caused by phobias. Providing referrals for appropriate psychiatric treatment is a critical nursing intervention.

SUMMARY OF KEY POINTS

- Anxiety is an unavoidable human condition. Anxiety becomes an anxiety disorder when anxiety and fear significantly interferes with social and occupational functioning.
- Anxiety-related disorders are the most common of all psychiatric disorders and comprise several disorders, including panic disorder.
- The anxiety disorders share the common symptom of recurring anxiety but differ in symptom profiles. Panic attacks can occur in many different disorders. Physical symptoms can mimic a heart attack.
- Panic disorder can occur throughout the lifespan but is most common in adulthood. Those experiencing anxiety disorders have a high level of physical and emotional illness and often experience dual diagnoses with other anxiety disorders, substance use disorder, or depression. These disorders often render individuals unable to function effectively at home or at a job.
- There appears to be a familial predisposition to panic disorders. Serotonin and norepinephrine are both implicated in panic disorders. The hypothalamic–pituitary–adrenal axis and activation of the stress hormones are also implicated in the expression of this disorder.
- Patients with panic disorder are often seen in various health care settings, frequently in hospital emergency departments or clinics, presenting with a confusing array of physical and emotional symptoms. Skillful assessment is required to eliminate possible life-threatening causes.
- Treatment approaches for all anxiety-related disorders are somewhat similar, including pharmacotherapy, psychological treatments, or often a combination of both.
- Antidepressants are the first-line medication treatment and are often included in psychosocial therapies such as cognitive-behavioral therapy, and exposure therapy. Virtual mental health strategies such as telehealth, mobile apps provide most of the same therapies as face-to-face therapies.
- Nursing interventions include helping patients manage a panic attack, promoting healthy diet, exercise and sleep hygiene habits, medication administration and monitoring, psychoeducation, and cognitive interventions.
- Many persons with panic disorders have other health problems that are treated in primary care. Mental and physical health needs should be integrated with both primary and mental health services.

CRITICAL THINKING CHALLENGES

1. A patient is unable to focus on your directions. He does not seem to notice others in the room; instead, he is intent on cutting his food into small pieces. Applying Peplau stages of anxiety, what level of anxiety is he experiencing?
2. Compare and contrast the following treatment modalities for anxiety disorders: systematic desensitization, implosive therapy, exposure therapy, and CBT.
3. Identify the major nursing assessment areas for a person experiencing a panic disorder.

4. A patient asks you how to prevent hyperventilation. How would you answer her question?
5. Delineate the differences in treatment effects of antidepressants versus antianxiety medication in the treatment of panic disorder.
6. Compare the various phobias that people experience. What interventions should a nurse use for a person who has a blood injection injury phobia?
7. How might one differentiate shyness from social anxiety disorder?

A related Psychiatric–Mental Health Nursing video on the topic of Anxiety is available at http://thepoint.lww.com/BoydEssentials3e.

Unfolding Patient Stories: Linda Waterfall • Part 2

Recall from Chapter 4 **Linda Waterfall,** a 48-year-old diagnosed with an aggressive form of breast cancer. The recommended treatment is a mastectomy followed by chemotherapy, which she refused. What is the association between her illness and episodes of severe anxiety since diagnosis? How can a secondary mental health disorder contribute to her physical decline from cancer? What psychosocial assessments and interventions should the nurse incorporate into the plan of care to manage her anxiety?

Care for Linda and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimMental Health). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

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