Theories: Anxiety Disorders

- Biological changes in the brain
  - Noradrenergic system is sensitive to norepinephrine; locus ceruleus is involved in precipitating panic attacks.
  - Dopamine system involved in pathophysiology of OCD.
  - GABA dysfunction affects development of panic disorder.

Theories: Anxiety Disorders - continued

- Abnormal control of glutamate plays role in anxiety disorders.
- Hormonal changes in pregnant women affect certain anxiety disorders.
- Lactic acid may precipitate anxiety.
- Caffeine and nicotine may trigger panic attacks.
Theories: Anxiety Disorders - continued

- Genetic theories: strong evidence for familial or genetic predisposition for anxiety disorders

Theories: Anxiety Disorders - continued

- Psychosocial theories: in psychoanalytic theory, anxiety is viewed as a sign of psychologic conflict; anxiety is the outcome of repressing forbidden impulses

Theories: Anxiety Disorders - continued

- Behavioral theory
  - Anxiety is a learned response that can be unlearned.
  - Compulsive behavior is a maladaptive attempt to alleviate anxiety.
  - Behavior modification teaches new ways to behave.
Theories: Anxiety Disorders - continued

- Humanistic theories:
  - Environmental stressors, biological factors, and intrapsychic fears cannot be dealt with separately but rather as they interact with one another.
  - Treatment approaches are integrative.

Theories: Dissociative Disorders

- Biological factors
  - Serotonin
  - Limbic system
  - Physical illnesses and certain drugs
  - Various personality states in dissociative identity disorder have different activity in frontal and temporal lobes.

Theories: Dissociative Disorders - continued

- Genetic theories:
  - Dissociative disorder occurs more often in first-degree biologic relatives
Theories: Dissociative Disorders - continued

- Psychosocial theories:
  - Current explanations are based on Freud’s dynamic concepts.
  - Repression of ideas leads to amnesia, to protect oneself from emotional pain.
  - Dissociative identity disorder is a result of childhood chronic trauma.

Theories: Dissociative Disorders - continued

- Behavioral theories:
  - Dissociative disorders are learned behaviors that provide protection from a painful experience.

Theories: Dissociative Disorders - continued

- Humanistic theories:
  - The person is a composite of life experiences, psychobiological factors, and interpersonal interactions.
Anxiety

- A universal experience
- A normal response that usually helps cope with threatening situations
- Anxiety disorders are characterized by anxiety so disabling as to adversely affect day-to-day functioning
- Affects all age groups

Anxiety - continued

- Anxiety disorders are most common of mental illnesses
- All anxiety disorders have in common excessive, irrational fear and dread
- Anxiety is either a dominant disturbance or an avoidance behavior
- Free-floating anxiety is unrelated to a specific stimulus

Anxiety - continued

- Panic disorder
- Phobia
- GAD
Interview with Steve

Click here to view a video interview with Steve, who has anxiety disorder.

Anxiety - continued

- Dissociation
  - Emotional numbing
  - Impaired social relationships
  - Separates emotions from behaviors
  - Consciousness, memory, identity, and/or perceptions of the environment are impaired.

Common Themes

- Anxiety disorders and dissociative identity disorder originate in childhood.
- Major common theme = disabling anxiety
- Other common features: personality and mood changes, distorted perceptions, inability to concentrate, memory impairment, defense mechanisms
Common Themes - continued

- Both anxiety and dissociative disorders may have underlying comorbid illnesses like depression or substance abuse.
- Both disorders profoundly affect quality of life.

- Psychotropic medications and teaching adaptive coping are mainstays of treatment.
- A holistic approach is best for caring for these clients.

Distinctive Characteristics

- Dissociation = common denominator of dissociative disorders
- Consciousness, memory, identity, and perception of environment are impaired.
- Disorders include dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalization disorder.
Care of Clients with Dissociative Disorders

- Dissociation is a defense against trauma that separates emotions from behaviors.
- Dissociation is a response to extreme childhood trauma.
- Consciousness, memory, identity, or perception of environment can be impaired.

Care of Clients with Dissociative Disorders - continued

- Most clients with dissociative disorder seen in community rather than inpatient settings
- Obtain subjective and objective data
- Complete psychosocial and physical assessment

Care of Clients with Dissociative Disorders - continued

- Decide whether priority is to alleviate symptoms or reintegrate anxiety-producing conflict.
- Behavioral modification helps alleviate some problematic behaviors.
Care of Clients with Dissociative Disorders - continued

- Provide safe, supportive environment.
- Teach desensitization to conflict.
- Medication plays a key role in treatment.

YOUR ASSESSMENT APPROACH:
The Client with Anxiety Disorder

Use the questions that follow as guidelines for assessing clients with anxiety disorders.

Physical Assessment
- Do you feel the floor moving (feet pounding)?
- Do you have difficulty breathing?
- Do you feel tense/sweaty? Are you aware, and how long does it last?
- How often do you experience changes in bladder or bowel function?
- How do your symptoms affect your sleep?

Psychological Assessment
- Do you feel sad and/or anxious?
- Do you feel unusually anxious?
- Do you feel detached from others?
- Have you ever been hospitalized?

Cognitive Assessment
- Do you worry about the worst things ever?
- Do you frequently have trouble concentrating on important activities?
- How often do you worry about the past or the future?
- Do you feel overly sensitive that was pleasantable for you in the past?

YOUR ASSESSMENT APPROACH:
The Client with Panic Attack

To determine the psychological effects of pain on your client, ask:
- How do you feel right now?
- Did you start feeling this way?
- Did it start gradually or all at once?
- How well are you able to concentrate?
- How do you feel about the future?
- Do you sometimes feel out of control?

To determine the somatic effects of pain on your client, ask:
- Are you having chest pain or shortness of breath?
- Have you felt dizzy or faint?
- Can you keep your hands steady, or do they shake?

YOUR ASSESSMENT APPROACH:
The Client with Panic Attack
YOUR ASSESSMENT APPROACH: The Client with Depersonalization Disorder

- To determine feeling of unreality, look for the following client statements:
  - “I don’t exist.”
  - “I’m not real.”
  - “I feel like I’m floating away.”
- To determine altered perceptions, look for the following client statements:
  - “My body doesn’t feel real.”
  - “I feel like I’m moving in a dream or the world is a dream.”
  - “My body feels numb.”
- To determine altered behavioral perceptions, look for the following client statements:
  - “I feel like I’m on a train, on a plane.”
  - “I’m going through the motions of a routine.”
- To determine altered perceptual experiences, look for the following client statements:
  - “I feel like I’m dreamwalking.”
  - “I feel like an automaton.”
  - “I feel like I’m not there.”

YOUR ASSESSMENT APPROACH: The Client with Dissociative Identity Disorder

- Are there blocks of time you are unable to remember?
- Have you ever awakened not knowing your name or where you were at that time?
- Do other people accuse you of being untruthful?
- Have you ever discovered unfamiliar objects, such as clothing, in your home and not known how they got there?
- Do you have headaches? If so, how often? How intense are they?
- How often do you have sleeping problems?
- Do you ever have nightmares?
- As a child, were you hurt or abused by others?

Comprehensive Assessment - continued

- Conduct a history and physical exam.
- Gather subjective and objective information.
- Interview family member(s) if possible.
Comprehensive Assessment - continued

- Complete psychosocial assessment to discover source of anxiety.
- Differentiate between anxiety and depression.
- Evaluate sleep and sleep quality.

Comprehensive Assessment - continued

- Complete suicide and homicide assessment.
- Major focuses for a client with dissociative disorder are identity, memory, and consciousness.

Plan of Care for Anxiety

- Mild to moderate anxiety
  - Use a calm, quiet approach
  - Observe client’s verbal/nonverbal behavior
  - Encourage client to verbalize feelings
Plan of Care for Anxiety - continued

Mild to moderate anxiety (cont.):
- Teach relaxation techniques (meditation, guided imagery, etc.) when anxiety is mild
- Simple physical activities often help reduce anxiety
- Develop goal-oriented contract

Severe to panic levels of anxiety:
- First priority is to reduce anxiety to tolerable levels.
- Stay with the client.
- Provide a safe and supportive milieu.
- Use a firm voice and short, simple sentences.

Severe to panic levels of anxiety (cont.):
- Place client in quieter, smaller, less stimulating environment; focus the client’s diffuse energy on repetitive task or tiring task.
- Administer anti-anxiety medication if ordered.
Client/Family Education

- Medications used to treat anxiety disorders include benzodiazepines, tricyclics, SSRIs and SNRIs, lithium, beta blockers, alpha-adrenergic antagonists, atypical antipsychotics, and neuroleptics.
- Teach about medication indications, side effects, and drug–drug interactions.

Client/Family Education - continued

Teaching about medications
- Drowsiness is a common side effect.
- Do not drink alcohol while taking.
- Drink decaffeinated beverages.
- Do not take other medications or adjust dosage in any way without consulting health care provider.

Client/Family Education - continued

Nonpharmacologic measures comprise effective coping skills:
- CBT techniques (desensitization, reciprocal inhibition, cognitive restructuring)
- Relaxation training
- Individual or group therapy
- Exercise and nutrition
Personal Challenges

- Anxiety is contagious.
- The nurse may be impatient and irritated by somatic complaints.
- It is important to identify the source of one’s own anxiety and consistently role-model adaptive behavior.

Personal Challenges - continued

- A client’s avoidance mechanism can be challenging to staff.
- Some nurses feel overwhelmed and helpless in the face of clients’ pain and catharsis.
- Ready answers are more likely to interfere with client’s communication.

Resources

- [http://www.adaa.org](http://www.adaa.org)
  The Anxiety Disorders Association of America (ADAA) is a national nonprofit organization dedicated to the prevention, treatment, and cure of anxiety disorders and to improving the lives of all people who suffer from them.
- [http://www.isst-d.org](http://www.isst-d.org)
  The International Society for the Study of Trauma and Dissociation is a professional association organized to develop and promote comprehensive, clinically effective, and empirically based resources and responses to trauma and dissociation.
Resources - continued

- http://www.ncptsd.va.gov/ncmain/information
  The National Center for Posttraumatic Stress Disorder Information Center provides information to interested individuals, including veterans and their family members.

- http://www.socialphobia.org
  The Social Phobia/Social Anxiety Association site offers further links to topics such as current news, treatment, and local group availability.