9.7: Applying the Nursing Process to Anxiety Disorders

People with anxiety disorders rarely require hospitalization unless they are suicidal, although anxiety can occur with other mental disorders requiring hospitalization. As a nurse working with individuals with diagnosed anxiety disorders, be aware of your self-reaction. It is not uncommon to have feelings of frustration, especially if you feel as if the symptoms are a matter of choice or under the client’s control. The client often acknowledges the fear is unrealistic or exaggerated but continues to engage in avoidant behavior. Recall that avoidant behavior is a symptom, and behavioral changes are accomplished slowly with treatment. [1]

It is also important to be aware that hospitalized patients may develop anxiety in association with other medical conditions (i.e., chronic obstructive pulmonary disease [COPD], angina, or hyperthyroidism) or medical procedures. Anxiety is a nursing diagnosis, as well as a potential mental health disorder. While implementing interventions that address medical conditions, often the nurse must also implement interventions that address associated anxiety.

Assessment

When assessing clients with anxiety, assess for the symptoms associated with the “fight or flight” stress response including the following [2]:

- Restlessness
- Altered concentration, attention, or memory
- Diminished ability to learn or problem solve
- Hypervigilance
- Fear
- Irritability or nervousness
• Hand tremors
• Increased perspiration
• Quivering voice
• Increased respiratory rate, heart rate, and blood pressure
• Palpitations
• Weakness
• Abdominal pain, nausea, or diarrhea
• Urinary urgency
• Altered sleep pattern

Determine the client's current level of anxiety (mild, moderate, severe, or panic) and assess for risk of suicide or self-harm. Perform a psychosocial assessment and focus on what factors could be contributing to the anxiety. For example, the client may identify a problem such as a relationship issue, stressful job, or school challenges that could be addressed by counseling. [3]

**Screening Tools**

The Severity Measure for Generalized Anxiety Disorder in Adults is a common tool for measuring anxiety. High scores may indicate generalized anxiety disorder or panic disorder, although it can also be associated with major depressive disorder.

View the [Severity Measure for Generalized Anxiety Disorder—Adult PDF screening tool.](#)

**Diagnostic and Lab Work**

When assessing for anxiety disorders, the provider will typically order lab work to rule out common medical causes of anxiety, such as hyperthyroidism, hypoglycemia, hypercalcemia, hyperkalemia, hyponatremia, or hypoxia. Review and/or monitor the results of these tests as part of the nursing assessment.

**Cultural Considerations**

Cultural beliefs can affect an individual’s expression of their feelings of anxiety. An example of a culture-mediated response related to anxiety and panic disorder is ataque de nervios (ADN) or “attack of the nerves” that may be exhibited in Hispanic populations. Symptoms of ADNs can vary widely but are typically described as an experience of distress characterized by a general sense of being out of control. The most common symptoms include uncontrollable shouting, attacks of crying, trembling, and heat in the chest rising into the head. Suicidal gestures, seizures, or fainting episodes may be observed. These symptoms are reported to typically occur following a distressing event such as an interpersonal conflict or the death of a loved one. [4]

**Diagnoses**

Anxiety is a NANDA-I nursing diagnosis and described as “vague, uneasy feeling of discomfort or dread accompanied
by an autonomic response; a feeling of apprehension caused by anticipation of danger. It is an alerting sign that warns of impending danger and enables the individual to take measures to deal with the threat.\textsuperscript{[5]} Read selected defining characteristics of anxiety in the preceding “Assessment” subsection or consult an evidence-based nursing care plan resource.

### Outcome Identification

The overall goal for anyone experiencing anxiety is to reduce the frequency and intensity of the anxiety symptoms. SMART outcomes are individualized to the client’s diagnosed conditions, situational factors, and current status. Planning outcomes in small, attainable steps can help a client gain a sense of control over their anxiety.\textsuperscript{[6]}

Examples of SMART outcomes include:

- The client’s vital signs will return to baseline within one hour.
- The client will identify and verbalize symptoms of anxiety by the end of the shift.
- The client will verbalize three preferred stress management and coping strategies for controlling their anxiety by the end of Week 1.

### Planning Interventions

The client should be encouraged to participate in planning outcomes and interventions tailored to their situation and needs. This will increase the likelihood that the interventions will be successful. Keep in mind that clients with severe anxiety or panic may not be able to participate in planning and rely on the nurse to take a directive role.\textsuperscript{[7]}

### Implementing Interventions

#### Safety

If a client is diagnosed with risk for suicide, interventions to maintain their safety receive priority. Review interventions for clients with a risk for suicide in the “Application of the Nursing Process in Mental Health Care” chapter.

If a client’s anxiety continues to escalate and they become agitated, measures must be taken to keep them and others safe. The nurse may find that administering prescribed medications, initiating time in a quiet room, seclusion, or restraints is required. Review crisis intervention in the “Stress, Coping, and Crisis Intervention” chapter. Review information regarding the use of seclusion and restraints in the “Psychosis and Schizophrenia” chapter.

#### Mild to Moderate Anxiety

The nurse can reduce a client’s anxiety level and prevent escalation by providing a calm presence in a quiet
environment, acknowledging their feelings of distress, and actively listening. Using therapeutic techniques like open-ended questions, distraction, exploring, and seeking clarification can be used to relieve the client’s feelings of tension and focus on previously successful coping strategies. — Review therapeutic communication techniques in the “Therapeutic Communication and the Nurse-Client Relationship” chapter.

It may be helpful to encourage the client to participate in physical activities that may provide relief from tension and increase endorphin levels. For example, the nurse can encourage the mildly anxious client to walk or play ping-pong.

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**Severe Anxiety to Panic**

A person experiencing severe anxiety to panic is often unable to solve problems or grasp what is going on in the environment. The nurse should also remain with a client experiencing acute, severe, or panic levels of anxiety. Therapeutic communication should focus on helping the client feel safe. Firm, short, simple statements using a slow, low-pitched voice are helpful.

In addition to keeping the client and others safe, priority nursing interventions for a client experiencing severe anxiety focus on the client’s physical needs, such as fluids to prevent dehydration, blankets for warmth, and rest to prevent exhaustion. If a person continues to constantly move or pace despite interventions, high-calorie finger foods may be offered to maintain their nutrition. Read additional interventions related to crisis intervention in the “Stress, Coping, and Crisis Intervention” chapter.

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**Evaluation**

Refer to the individualized SMART outcomes established for each client when evaluating the effectiveness of interventions in the care plan. In general, evaluation of outcomes with clients with anxiety disorders includes the following questions:

- Is the client experiencing a reduced level of anxiety?
- Does the client recognize their symptoms are related to anxiety?
- Is the client successfully implementing adaptive coping strategies to manage their anxiety?
- Is the client adequately performing self-care activities (e.g., hygiene, eating, and elimination)?
- Is the client able to maintain satisfying interpersonal relationships?
- Is the client able to successfully function socially, occupationally, or in other important areas of functioning?

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