

GENERALIZED ANXIETY DISORDER

DSM-IV

300.02 Generalized anxiety disorder

Although some degree of anxiety is normal in life's stresses, anxiety can be adaptive or maladaptive. Problems arise when the client has coping mechanisms that are inadequate to deal with the danger, which may be recognized or unrecognized. The essential feature of this inadequacy is unrealistic or excessive anxiety and worries about life circumstances. Anxiety disorders are the most common of all major groups of mental disorders in the United States, sharing comorbidity with major depression and substance abuse, increasing the client's risk of suicide.

ETIOLOGICAL THEORIES

Psychodynamics

The Freudian view involves conflict between demands of the id and superego, with the ego serving as mediator. Anxiety occurs when the ego is not strong enough to resolve the conflict. Sullivanian theory states that fear of disapproval from the mothering figure is the basis for anxiety. Conditional love results in a fragile ego and lack of self-confidence. The individual with anxiety disorder has low self-esteem, fears failure, and is easily threatened.

Dollard and Miller (1950) believe anxiety is a learned response based on an innate drive to avoid pain. Anxiety results from being faced with two competing drives or goals.

Cognitive theory suggests that there is a disturbance in the central mechanism of cognition or information processing with the consequent disturbance in feeling and behavior. Anxiety is maintained by this distorted thinking with mistaken or dysfunctional appraisal of a situation. The individual feels vulnerable, and the distorted thinking results in a negative outcome.

Biological

Although biological and neurophysiological influences in the etiology of anxiety disorders have been investigated, no relationship has yet been established. However, there does seem to be a genetic influence with a high family incidence.

The autonomic nervous system discharge that occurs in response to a frightening impulse and/or emotion is mediated by the limbic system, resulting in the peripheral effects of the autonomic nervous system seen in the presence of anxiety.

Some medical conditions have been associated with anxiety and panic disorders, such as abnormalities in the hypothalamic-pituitary-adrenal and hypothalamic-pituitary-thyroid axes, acute myocardial infarction, pheochromocytomas, substance intoxication and withdrawal, hypoglycemia, caffeine intoxication, mitral valve prolapse, and complex partial seizures.

Family Dynamics

The individual exhibiting dysfunctional behavior is seen as the representation of family system problems. The "identified patient" (IP) is carrying the problems of the other members of the family, which are seen as the result of the interrelationships (disequilibrium) between family members rather than as isolated individual problems.

It is recognized that multiple factors contribute to anxiety disorders.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Restlessness, pacing anxiously, or, if seated, restlessly moving extremities
Feeling “keyed up”/“on edge,” unable to relax
Easily fatigued
Difficulty falling or staying asleep; restlessness, unsatisfying sleep

Circulation

Heart pounding or racing/palpitations; cold and clammy hands; hot or cold spells, sweating; flushing, pallor
High resting pulse, increased blood pressure

Ego Integrity

Excessive worry about a number of events/activities, occurring more days than not for at least 6 months
Complains vociferously about inner turmoil, has difficulty controlling worry
May demand help
Facial expression in keeping with level of anxiety felt (e.g., furrowed brow, strained face, eyelid twitch)
May report history of threat to either physical integrity (illness, inadequate food and housing, etc.) or self-concept (loss of significant other; assumption of new role)

Elimination

Frequent urination; diarrhea

Food/Fluid

Lack of interest in food, dysfunctional eating pattern (e.g., responding to internal cues other than hunger)
Dry mouth, upset stomach, discomfort in the pit of the stomach, lump in the throat

Neurosensory

Absence of other mental disorder, such as depressive disorder or schizophrenia
Motor tension: shakiness, jitteriness, jumpiness, trembling, muscle tension, easily startled
Dizziness, lightheadedness, tingling hands or feet
Apprehensive expectation: anxiety, worry, fear, rumination, anticipation of misfortune to self or others, inability to act differently (feeling stuck)
Excessive vigilance/hyperattentiveness resulting in distractibility, difficulty in concentrating or mind going blank, irritability, impatience
Free-floating anxiety usually chronic or persisting over weeks/months

Pain/Discomfort

Muscle aches, headaches

Respiratory

Increased respiratory rate, shortness of breath, smothering sensation

Sexuality

Women twice as likely to be affected as men

Social Interactions

Significant impairment in social/occupational functioning

Teaching/Learning

Age of onset usually 20s and 30s

DIAGNOSTIC STUDIES

Drug Screen: Rules out drugs as contribution to cause of symptoms.

Other diagnostic studies may be conducted to rule out physical disease as basis for individual symptoms (e.g., ECG for severe chest pain, echocardiogram for mitral valve prolapse; EEG to identify seizure activity; thyroid studies).

NURSING PRIORITIES

1. Assist client to recognize own anxiety.
2. Promote insight into anxiety and related factors.
3. Provide opportunity for learning new, adaptive coping responses.
4. Involve client and family in educational/support activities.

DISCHARGE GOALS

1. Feelings of anxiety recognized and handled appropriately.
2. Coping skills developed to manage anxiety-provoking situations.
3. Resources identified and used effectively.
4. Client/family participating in ongoing therapy program.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

ANXIETY [severe]/POWERLESSNESS

Real or perceived threat to physical integrity or self-concept (may or may not be able to identify the threat)

Unconscious conflict about essential values (beliefs) and goals of life; unmet needs

Negative self-talk

Persistent feelings of apprehension and uneasiness (related to unidentified stressor or stimulus) that client has difficulty alleviating

Sympathetic stimulation; restlessness; extraneous movements (foot shuffling, hand/arm fidgeting, rocking movements)

Poor eye contact; focus on self

Desired Outcomes/Evaluation Criteria—

Client Will:

Impaired functioning; verbal expressions of having no control or influence over situation, outcome, or self-care

Free-floating anxiety

Nonparticipation in care or decision-making when opportunities are provided

Verbalize awareness of feelings of anxiety.

Identify effective coping mechanisms to successfully deal with stress.

Report anxiety is reduced to a manageable level.

Demonstrate problem-solving skills/lifestyle changes as indicated for individual situation.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Establish and maintain a trusting relationship through the use of warmth, empathy, and respect. Provide adequate time for response. Communicate support of the client's self-expression.

Be aware of any negative or anxious feelings nurse may have because of client's conscious or unconscious resistance of nurse's helpful efforts.

Identify behaviors of the client that produce anxiety in the nurse. Explore these behaviors with the client once relationship is established.

Use supportive confrontation as indicated.

Have client identify and describe the sensations of emotional and physical feelings. Assist the client to link behavior and feelings. Validate all inferences and assumptions with the client.

Help to explore conflictual issues by beginning with nonthreatening topics and progressing to more conflict-laden ones.

Monitor the anxiety level of the nurse/client interaction on an ongoing basis.

The client may perceive the nurse as a threat, which may increase the client's anxiety. Attending behaviors can increase the degree of comfort the client experiences with the nurse.

Negative reactions to the client will block future progress. Anxiety is "contagious," and nurse needs to recognize and control own anxiety.

Promotes growth and change and helps client realize how own behavior affects others.

Confrontation can be useful when client's progress is blocked but may heighten anxiety to a level that is detrimental to the therapy process. Therefore, it should be used with caution.

To adopt new coping responses, the "5 R's" of anxiety reduction are used. The client first needs to **RECOGNIZE** anxiety and be aware of feelings, how they link to certain maladaptive coping responses, and own responsibility in learning to control behavior.

Anxious client does not think clearly, and beginning with simple topics promotes comfort level, increasing sense of success and progress.

Moderate anxiety may be productive for/motivate client, but too high a level of anxiety can interfere with the interaction and ability to attend to information.

Assist the client to identify the situations and interactions that immediately precede the anxiety. Suggest that the client keep an “anxiety notebook” that focuses on feelings and what is going on in the environment when anxious feelings begin.

Help client correlate cause-and-effect relationships between stressor and anxiety.

Note when reports of anxiety move from one concern to another (e.g., money, health, relationships), and help client recognize what is happening.

Link the present experience with relevant ones from the past. Ask questions like, “Does that seem familiar to you? What does it remind you of from the past?”

Explore how client dealt with anxiety in the past and what methods produced relief. Encourage use of adaptive coping responses that have worked in the past.

Include significant others as resources and social supports in helping client learn new coping responses.

Ask client to remember times when she or he anticipated the worst and it did *not* happen. Focus attention on those situations.

Encourage and support more realistic thoughts, e.g., “I don’t know for certain that (blank) will happen.” “Whatever happens, I can manage.” “I’ll delay worrying for now and think about something calming.”

Keep the focus of responsibility for change on the client.

Expose client slowly to anxiety-provoking situations; use role-playing as appropriate.

After the client recognizes feelings of anxiety, examination of the development of the anxiety (e.g., what precipitates it, the strength of the stressor[s]) and what resources are available can help the client develop new coping skills. Therapeutic writing serves to decrease the anxiety while the client is learning about it, making it more tangible/controllable.

Gives more control over situation. Increases sense of power if client can identify cause of anxiety.

Feelings of anxiety can become “free-floating,” becoming attached to one concern after another, and the client needs to recognize this so it can be dealt with.

Provides opportunity for client to make connections between these events and development of current anxiety, promoting insight and learning experience.

Increases confidence in own ability to deal with stress. The client is capable of learning new, adaptive coping responses by analyzing coping mechanisms used previously, identifying available resources, and accepting personal responsibility for change, effectively **REMOVING** the threat or stressors underlying the anxiety. (Refer to ND: Coping, Individual, ineffective.)

Enhances ability to cope when one does not feel alone. In addition, because anxiety may have an interpersonal basis, involvement of SO(s) can enhance the client’s relationship skills. **RELATIONSHIPS** can provide support, help, and reassurance, enabling the use of others as resources rather than using withdrawal to cope.

May be useful to help client understand the dynamics of negative thinking and its relationship to feelings of anxiety.

Replacing negative thoughts with positive or calming thoughts can be helpful in stopping the cycle of negative thinking.

Increases feelings of self-control and self-esteem.

RE-ENGAGEMENT allows the client time to identify/implement and practice new, adaptive coping responses and to become comfortable in using them.

Assist to reevaluate goals, modify behavior, use resources, and test out new coping responses.

Develop regular physical activity program.

Encourage client to use relaxation techniques (e.g., meditation, massage, breathing techniques, exercises, guided imagery, and biofeedback).

Collaborative

Administer medication as indicated, e.g., buspirone (BuSpar), benzodiazepines, e.g., alprazolam (Xanax), clonazepam (Klonopin), clorazepate (Tranxene), chloridiazepoxide (Librium), diazepam (Valium), oxazepam (Serax).

Goals may have been too rigid and may have set up client for anxiety that could be avoided by change in behavior/responses.

Excess energy is discharged in a healthful manner through physical exercise. Biochemical effects of exercise therapy decrease feelings of anxiety.

RELAXATION is the ultimate stress management technique because it brings about a decreased heart rate, lowers metabolism, and decreases respiration rate. The relaxation response is the physiological opposite of the anxiety response.

Anxiolytics provide relief from the immobilizing effects of anxiety. BZDs have few side effects, are generally well tolerated, have a fairly rapid rate of onset, and do not impair sleep. **Note:** When anxiety is associated with depression, anti-depressant agents alone may provide relief of symptoms. Unlike BZDs, BuSpar is nonaddicting, has a delayed onset of action (10 days–2 weeks), and must be taken on a regular basis (not PRN).

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

COPING, INDIVIDUAL, ineffective

Level of anxiety being experienced by client

Inadequate coping methods

Personal vulnerability; unmet expectations; inadequate support systems

Little or no exercise

Multiple stressors, repeated over period of time

Maladaptive coping skills; verbalization of inability to cope

Chronic worry, emotional tension; muscular tension/headaches; chronic fatigue, insomnia

Inability to problem-solve

Alteration in societal participation

High rate of accidents; overeating, excessive smoking, or drinking/drug use

Identify ineffective coping behaviors and consequences.

Express feelings appropriately.

Identify options and use resources effectively.

Use effective problem-solving techniques.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess current functional capacity, developmental level of functioning, and level of coping. Determine defense mechanisms used (e.g., denial, repression, conversion, dissociation, reaction formation, undoing, displacement or projection).

Identify previous methods of coping with life problems.

Determine use of substances (e.g., alcohol, other drugs; smoking habits; eating patterns).

Observe and describe behavior in objective terms. Validate observations with client as possible. Note physical complaints.

Assess for premenstrual tension syndrome, when indicated.

Active-listen client concerns and identify perceptions of what is happening.

Confront client behaviors in context of trusting relationship, pointing out differences between words and actions, when appropriate.

Help client identify maladaptive effects of present coping mechanisms.

Provide information about different ways to deal with situations that promote anxious feelings (e.g., identification and appropriate expression of feelings and problem-solving skills).

Use role-play and rehearsal techniques as indicated.

Encourage and support client in evaluating lifestyle, noting activities and stresses of family, work, and social situations.

Have client identify short- and long-term goals that are attainable, prioritized according to individual client needs and realistic time requirements. feelings of powerlessness.

Knowing how client's coping ability is affected by current events determines need for/type of intervention. People tend to regress during illness/crisis and need acceptance and support to regain/improve coping ability.

How client has handled in the past problems is a reliable predictor of how current problems will be handled.

Substances are often used as coping mechanism to control anxiety and can interfere with client's ability to deal with current situation.

Provides accurate picture of client situation and avoids judgmental evaluations. Anxious people may have increased somatic concerns. (Refer to CP: Somatoform Disorders.)

Increased progesterone may cause increased anxiety for women during the luteal phase of the menstrual cycle.

Promotes sense of self-worth and value for beliefs and clarifies client view of situation.

Helps client to become aware of distortions of reality resulting from anxiety state.

Promotes understanding of relationship of what the individual does to undesired consequences.

Provides opportunity for client to learn new coping skills and incorporate these into own lifestyle.

Promotes practice of new skills in a nonthreatening environment.

Helps client to look at difficult areas that may contribute to anxiety and to make changes gradually without undue/debilitating anxiety.

Helps provide direction, enables evaluation of progress, promotes feelings of success as goals are attained. Unrealistic goals set client up for failure and reinforce

Recommend dividing tasks into manageable units. Let client know it is OK to say “No” to requests for additional work/other commitments.

Suggest simplifying work environment; interrupting stressful periods with breaks for relaxation.

Emphasize importance of structuring life to provide adequate exercise/sleep, diversional activities, and nutrition.

Collaborative

Refer to outside resources (e.g., support groups, psychotherapy/counselor, spiritual advisor, sexual counseling) as indicated.

Focuses on achieving goals by small steps. Giving permission to refuse to take on more than client can handle frees individual from added stressors, increasing likelihood of success.

Enhances coping skills by reducing distractions, promoting sense of control, and allowing individual to return to task refreshed.

Structure provides feeling of security for the anxious client. Promotes a less stressful lifestyle, enhances feelings of general well-being and ability to cope.

May need additional assistance or support to maintain improvement/control.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

SOCIAL INTERACTION, impaired/SOCIAL ISOLATION

Use of unsuccessful social interaction behaviors

Inadequate personal resources; absence of available significant others/peers

Self-concept disturbance

Altered mental status, hypervigilance

Verbalized/observed discomfort in social situations; dysfunctional interactions

Expression of feelings of difference from others; preoccupation with own thoughts, irritability, impatience, difficulty in concentrating

Sad, dull affect; uncommunicative, withdrawn behavior; absence of eye contact

Recognize anxiety and identify factors involved with feelings of isolation/impaired social interactions.

Participate in activities to enhance interactions with others.

Give self positive reinforcement for changes that are achieved.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Listen to client comments regarding sense of isolation. Differentiate isolation from solitude and loneliness.

Spend time with client, discussing areas of concern (e.g., reasons anxious feelings interfere with ability to be involved with others). Express positive regard for the client; Active-listen concerns.

Develop plan of action with client; look at available resources, risk-taking behaviors, appropriate self-care.

Assess client's use of coping skills and defense mechanisms.

Help client learn social skills and use role-playing for practice.

Encourage journal-keeping and daily recording of social interactions for review.

Recommend that client share/discuss situation with peers/coworkers.

Collaborative

Involve in classes/programs directed at resolution of problems (e.g., assertiveness training, group therapy, outdoor education program).

Provides information about individual concerns/problems of feelings of aloneness. Client may not be aware of difference between being alone by choice and feeling of being alone even when others are around.

Provides opportunity for learning ways to deal with feelings of anxiety in social situations. Communicates belief in client's self-worth and provides safe environment for self-disclosure.

Involvement of client communicates sense of competence and ability to change behavior, even in presence of anxious feelings.

Awareness of defenses individual is using provides for choice of changing behavior. Helps to develop skills that can be used to manage anxiety and promote social interaction.

Provides for new ways to handle anxiety in interaction with others.

Helps client recognize the comfort/discomfort that is experienced and possible causes, providing insight that may reduce anxiety. Therapeutic writing is also useful in evaluating individual responses/coping behaviors. (Refer to ND: Coping, Individual, ineffective.)

Helps others understand condition, reducing risk of misinterpretation and decreasing individual anxiety. Provides opportunity for client to hear own words, gain new perspective, and begin to problem-solve new ways of handling stressors.

Developing positive social skills/behaviors provides opportunity for diminishing anxiety and promoting involvement with others.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:****SLEEP PATTERN disturbance**

Psychological stress

Repetitive thoughts

Reports of difficulty in falling asleep/awakening earlier or later than desired; not feeling rested

Dark circles under eyes; frequent yawning

Verbalize understanding of relationship of anxiety and sleep disturbance.

Identify appropriate interventions to promote sleep.

Report improvement in sleep pattern, increased sense of well-being, and feeling well-rested.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Determine type of sleep pattern disturbance present, including usual bedtime, rituals/routines, number of hours of sleep, time of arising, environmental needs, and how much of a problem it is to client.

Provide quiet environment, comfort measures (e.g., back rub, wash hands/face, bath), and sleep aids, such as warm milk. Restrict use of caffeine and alcohol before bedtime.

Discuss use of relaxation techniques/thoughts, visualization.

Suggest ways to handle waking/not sleeping (e.g., do not lie in bed and think, but get up and remain inactive, or do something boring).

Involve client in exercise program, avoiding exercise within 2 hours of going to bed.

Avoid use of sedatives, when possible.

Identification of individual situation and degree of interference with functioning determines need for/appropriate interventions.

Promotes relaxation and cues for falling asleep. Stimulating effects of caffeine/alcohol interfere with ability to fall asleep.

Promotes reduction of anxious feelings, resulting in improved sleep/rest.

Having a plan can reduce anxiety about not sleeping.

Increases fatigue, promotes sleep but avoids excessive stimulation from activity before bedtime.

Sedative drugs interfere with REM sleep and affect quality of rest. A rebound effect may lead to intense dreaming, nightmares, and more disturbed sleep.

Collaborative

Administer medications as indicated, e.g., zolpidem (Ambien).

Although drug is recommended for short-term use only, it may be beneficial until other therapeutic interventions are successful.

NURSING DIAGNOSIS

Risk Factors May Include:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Family Will:

FAMILY COPING: ineffective, risk for compromised

Inadequate or incorrect information or understanding by a primary person

Temporary family disorganization and role changes

Prolonged disability that exhausts the supportive capacity of significant other(s)

[Not applicable, presence of signs and symptoms establishes an *actual* diagnosis.]

Identify resources within themselves to deal with situation.

Interact appropriately with the client, providing support and assistance as needed.

Recognize own needs for support, seek assistance, and use resources effectively.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess information available to and understood by family/SO(s).

Identify client's role in family and how the illness has changed the family organization (e.g., mother who does not maintain household, father who does not go to work).

Note other factors besides illness (e.g., anxiety, personality disorders) that affect family members' ability to provide needed support.

Discuss underlying reasons for client's behaviors.

Lack of understanding of client's behavior can lead to dysfunctional interactional patterns, which contribute to anxiety in family members.

Degree of disability suffered by the client that interferes with performance of usual family role can contribute to family stress/disorganization.

Systems theory maintains that other members of the family also exhibit dysfunctional behavior, but the client is the "identified patient."

Helps family understand and accept behaviors that may be difficult to handle.

Assist family and client to understand who “owns” the problem and who is responsible for resolution.

Encourage development of problem-solving skills.

Collaborative

Refer to appropriate resources as indicated (e.g., counseling, psychotherapy; financial, spiritual advisors).

Promotes responsibility of knowing that whoever has the problem has to solve it. The individual can ask for help, but others do not rescue or try to solve it for the person.

Helps family learn new ways to deal with conflicts and reduce anxiety-provoking situations.

May need additional assistance to maintain family integrity.