

PANIC DISORDER/PHOBIAS

DSM-IV

PANIC DISORDER/PHOBIAS

- 300.01 Panic disorder without agoraphobia
- 300.21 Panic disorder with agoraphobia
- 300.22 Agoraphobia without history of panic disorder
- 300.23 Social phobia
- 300.29 Specific phobia

Panic attack is a discrete period of intense fear or discomfort with onset spontaneous/unpredictable or situationally bound, peaking within 10 minutes.

ETIOLOGICAL THEORIES

Psychodynamics

Phobic object may symbolize the underlying conflict, although there is not always a clear connection. Personal perceptions, life experiences, and cultural values color the meaning of the symbol for the client.

The Freudian view is that anxiety feelings stem from loss of love and support from the mothering figure, which increases the client's dependency needs. The client combats the diffuse intolerable anxiety by an exaggerated use of displacement on a particular object or situation, which makes the anxiety more manageable.

Phobic partners may develop in the family; these are "helpers" who stand by and participate in maintaining phobic behavior, protecting phobic client from acute panic and anxiety. Participation of partner furthers the unconscious wish of phobic client to be taken care of and to be in control.

Biological

(Refer to CP: Generalized Anxiety Disorder.)

Temperament may be a factor in that some fears are innate. These fears represent a part of the overall characteristics with which one is born that influence how the individual responds to specific situations throughout his or her life. Research suggests irregularities in the synthesis and release of norepinephrine and/or hypersensitivity of receptors for neurotransmitters (including serotonin and gamma-aminobutyric acid [GABA]), or an interaction between norepinephrine transmitters. The trigger may lie in the locus coeruleus located in the brainstem. There also may be a genetic susceptibility to either an excess or deficiency of CO₂ levels and a sensitivity to lactate associated with the panic attack.

Family Dynamics

(Refer to CP: Generalized Anxiety Disorder.)

CLIENT ASSESSMENT DATA BASE

Circulation

- Palpitations or tachycardia
- Sweating, hot flashes, or chills

Ego Integrity

A persistent fear of some object/situation that poses no actual danger or in which the danger is magnified out of proportion to its seriousness; tries to avoid or escape contact with the feared object or situation
Degree of discomfort may vary from mild anxiety to incapacitation; may be unable to move, speak, or identify ways of decreasing anxiety or may begin running about aimlessly and shouting
May express a sensation of dread and a certain knowledge that death is at hand or may fear dying, going crazy, or doing something uncontrolled

Food/Fluid

Nausea/abdominal distress

Neurosensory

May exhibit one of three types of phobias:

Agoraphobia: Fears any situation in which individual may feel helpless or humiliated if a panic attack should occur and client cannot readily escape from public view

Specific/Simple Phobia: Fear involving specific objects such as spiders or snakes or situations such as heights, darkness, or closed spaces

Social Phobia: Fear of talking or writing in public and/or eating, blushing, urinating, etc.; fear of these behaviors resulting in public scorn

Preoccupied with bodily symptoms and feelings of terror

Feelings of faintness, dizziness, or lightheadedness; trembling/shaking; paresthesias (numbness or tingling sensations)

May experience brief periods of delusional thinking, hallucinations, inability to test reality

Depersonalization or derealization

Pain/Discomfort

Chest pain or discomfort

Respiratory

Shortness of breath (dyspnea); smothering sensations, choking; hyperventilation, labored breathing

Sexuality

Occurs more frequently in women than in men

May avoid sexual involvement because of fear of arousal, particular sexual acts, and/or relationships

Social Interactions

More common among people who have experienced an early traumatic loss, such as the death of a parent

Manipulates environment and depends on others to avoid confrontation with the object or situation

Some constriction of life activities present

Teaching/Learning

Usually begins in late teens or early adulthood (panic attacks rare after age 65)

Attacks may be associated with magic or witchcraft

No history of a physical disorder (e.g., hyperthyroidism, hypoglycemia), although mitral valve prolapse is common

May report other disorders such as major depression, somatization disorder, schizophrenia, personality disorder

Increased rate of alcohol abuse

DIAGNOSTIC STUDIES

Drug Screen: Identifies drugs that may be used by client to reduce anxiety, rules out drugs that may produce symptoms.

Other diagnostic studies may be conducted to rule out physical disease as a basis for individual symptoms, e.g.:

EEG: To rule out epilepsy, other neurological disorders.

EKG: In the presence of severe chest pain to rule out cardiac conditions.

Thyroid Studies: To rule out hyperthyroidism.

NURSING PRIORITIES

1. Provide for physical safety.
2. Assist client to recognize onset of anxiety.
3. Help client learn alternative responses.
4. Assist with desensitization to phobic object/situation, if present.
5. Promote involvement of client/family in group or community support activities.

DISCHARGE GOALS

1. Stays in feared situation even when discomfort is experienced.
2. Identifies techniques to lower/keep fear at manageable level.
3. Confronts the phobia and is desensitized to the stimulus.
4. Demonstrates greater independence and an increasingly freer lifestyle.
5. Plan in place to meet needs after discharge.

(Refer to CP: Generalized Anxiety Disorder for needs/concerns in addition to the following NDs.)

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria—

Client Will:

FEAR

Unfounded morbid dread of a seemingly harmless object/situation (e.g., fear of being alone in public places, snakes, spiders, dark, heights, stormy weather [virtually any object/situation])

Physiological symptoms, mental/cognitive behaviors indicative of panic

Withdrawal from or total avoidance of situations that place client in contact with feared object

Acknowledge and discuss fears.

Demonstrate understanding through use of effective coping behaviors and active participation in treatment regimen.

Resume normal life activities.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Encourage discussion of the phobia. Investigate sexual concerns, noting problems expressed (e.g., sex is a duty/obligation that is not enjoyed by the client).

Only when a difficulty is acknowledged can it be dealt with. **Note:** Phobic reaction to sex may indicate a problem of incest/sexual abuse.

Provide for client's safety (e.g., a secure environment, staying with the client, letting the client know the nurse will provide for safety).

In severe anxiety, client fears total disintegration and loss of control.

Suggest that the client substitute positive thoughts for negative ones.

Emotion connected to thought, and changing to a more positive thought can decrease the level of anxiety experienced. This also gives the client an alternative way of looking at the problem.

Discuss the process of thinking about the feared object/situation before it occurs.

Anticipation of a future phobic reaction allows client to deal with the physical manifestations of fear.

Encourage client to share the seemingly unnatural fears and feelings with others, especially the nurse therapist.

Clients are often reluctant to share feelings for fear of ridicule and may have repeatedly been told to ignore feelings. Once the client begins to acknowledge and talk about these fears, it becomes apparent that the feelings are manageable.

Share own experience with client as indicated after relationship has been established.

If nurse therapist has dealt successfully with phobia in own life, client may be encouraged by the fact that someone has overcome a similar problem. Use judiciously to avoid meeting own needs rather than focusing on the client's needs.

Encourage to stop, wait, and not rush out of feared situation as soon as experienced. Support use of relaxation exercises (e.g., breath control, muscle relaxation, self-hypnosis).

Client fears disorganization and loss of control of body and mind when exposed to the fear-producing stimulus. This fear leads to an avoidance response, and reality is never tested. If client waits out the beginnings of anxiety and decreases it with relaxation exercises, then she or he may be ready to continue confronting the fear.

Explore things that may lower fear level and keep it manageable (e.g., use of singing while dressing, practicing positive self-talk while in a fearful situation).

Provides the client with a sense of control over the fear. Distracts the client so that fear is not totally focused on and allowed to escalate.

Use desensitization approach, e.g.:

Systematic desensitization (gradual systematic exposure of the client to the feared situation under controlled conditions) allows the client to begin to overcome the fear, become desensitized to the fear. **Note:** Implosion or flooding (continuous, rapid presentation of the phobic stimulus) may show

Expose client to a predetermined list of anxiety-provoking stimuli rated in hierarchy from the least frightening to the most frightening.

Pair each anxiety-producing stimulus (e.g., standing in an elevator) with arousal of another affect of an opposite quality (e.g., relaxation, exercise, biofeedback) strong enough to suppress anxiety.

Help client to learn how to use these techniques when confronting an actual anxiety-provoking situation. Provide for practice sessions (e.g., role-play), deal with phobic reactions in real-life situations.

Encourage client to set increasingly more difficult goals.

Collaborative

Administer antianxiety medications as indicated: benzodiazepines, e.g., alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), lorazepam (Ativan), chlordiazepoxide (Librium), oxazepam (Serax).

Involve in interoceptive exposure therapy as appropriate, with client holding breath, hyperventilating and inhaling CO₂, or receiving sodium lactate injections as indicated.

quicker results than systematic desensitization, but relapse is more common or client may become terrified and withdraw from therapy.

Experiencing fear in progressively more challenging but attainable steps allows client to realize that dangerous consequences will not occur. Helps extinguish conditioned avoidance response.

Helps client to achieve physical and mental relaxation as the anxiety becomes less uncomfortable.

Client needs continued confrontation to gain control over fear. Practice helps the body become accustomed to the feeling of relaxation, enabling the individual to handle feared object/situation.

Develops confidence and movement toward improved functioning and independence.

Biological factors may be involved in phobic/panic reactions, and these medications (particularly Xanax) produce a rapid calming effect and may help client change behavior by keeping anxiety low during learning and desensitization sessions. Addictive tendencies of CNS depressants need to be weighed against benefit from the medication.

Alters client's response to internal sensations as client learns that the feelings associated with panic do not indicate impending disaster.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

ANXIETY [severe to panic]

Unidentified stressor(s)

Contact with feared object/situation

Limitations placed on ritualistic behavior

Attacks of immobilizing apprehension

Physical, mental, and cognitive behaviors indicative of panic

Expressed feelings of terror and inability to cope

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Verbalize a reduction in anxiety to a manageable level.

Use individually appropriate techniques to interrupt progression of anxiety to panic level.

Demonstrate increasing tolerance to phobic object/situation.

Identify and use resources effectively.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Establish and maintain a trusting relationship by listening to the client; displaying warmth, answering questions directly, offering unconditional acceptance; being available and respecting the client's use of personal space.

Therapeutic skills need to be directed toward putting the client at ease, because the nurse who is a stranger may pose a threat to the highly anxious client.

Be aware and in control of *own* feelings; explore the cause of own anxiety and use this understanding therapeutically.

The nurse's anxiety can be communicated to the client, which only adds to the client's sense of terror. Discussion of these feelings can provide a role model for the client and show a different way of dealing with them.

Provide simple, clear explanations and instructions.

During period of increased anxiety, client may have difficulty focusing on/comprehending communications.

Support the client's defenses initially.

The client uses defenses in an attempt to deal with an unconscious conflict, and giving up these defenses prematurely may cause increased anxiety.

Verbally acknowledge the reality of the pain of the client's present coping mechanism (panic) without focusing on the symptoms that are being expressed.

The symptoms that the client is experiencing relieve some of the intolerable anxiety felt by the client. If client is unable to release this tension, the anxiety will only increase, possibly causing client to lose control.

Provide feedback about behavior, stressors, and coping responses. Validate what you observe with the client.

Sets groundwork for dealing with anxiety when client is calmer. Includes client in plan of care, providing sense of control/self-worth.

Emphasize relationship between physical and emotional health, and reinforce that this is an area to be explored when client feels better.

Client needs to be aware of mind-body relationship and the physiological changes that cause discomfort.

Observe for increasing anxiety. Assume a calm manner, decrease environmental stimulation, and provide temporary isolation as indicated.

Early detection and intervention facilitate modifying client's behavior by changing the environment and the client's interaction with it, to minimize the spread of anxiety.

Assist client/family to recognize and modify situations that cause anxiety when precipitating factor can be identified. (**Note:** Simple phobias are usually specific and object-centered; this is not so with all phobic disorders.)

Determine/discuss use of alcohol and other drugs.

Note diagnosis of mitral valve prolapse.

Determine use of caffeine-containing beverages.

Suggest supportive physical measures, such as warm baths/whirlpool, massage.

Encourage interest in outside activity through the following actions:

Share an activity with the client;

Provide for physical exercise/activity of some type within client toleration;

Structure the client's day with a list of planned activities realistic to client's capabilities. Include others in providing client care and support.

Identify signs/symptoms of escalating anxiety and appropriate responses (e.g., relaxation, stopping negative self-talk).

Assess suicidal ideation.

Discuss side effects of medications, noting reactions that may occur (e.g., drowsiness, ataxia, confusion, headache, slurred speech, lethargy, giddiness, dizziness, vertigo, and impaired visual accommodation).

Involve in cognitive behavioral techniques such as rational-emotive therapy and self-instruction.

Recognition of causes/relationships provides opportunity to intervene before anxiety escalates or loss of control occurs.

May be used to reduce anxiety/avoid panic attacks and can lead to abuse. (Refer to Ch. 5, Substance-Related Disorders.)

This cardiac abnormality affects between Qr and Qw of panic disorder clients. Heart palpitations resulting from the failure of the valve to close properly can increase anxiety and trigger panic attacks.

These clients may be more sensitive to the anxiety-producing effects of caffeine, which may precipitate panic/anxiety attacks.

Provides physical relaxation and helps client manage anxiety/maintain control.

Increases participation in life while decreasing the amount of time and energy available for maladaptive coping mechanisms.

This is emotionally supportive and reinforces socially acceptable behavior.

Uses energy in constructive ways. Endorphins (the body's naturally produced "narcotics") induce feelings of wellness/euphoria and are thought to be released during exercise. **Note:** Use exercise therapy with caution, as half of clients have increased anxiety with exercise.

Provides opportunity to experience success, which enhances self-esteem and increases self-confidence.

Helps client become proactive in interrupting progression of anxiety to panic. Enhances sense of control.

These individuals have an increased rate of suicide/suicide attempts. This is of particular concern when therapeutic treatment of major depression lifts client's mood to the point at which she or he can act on suicidal thoughts.

Side effects of antianxiety medications may cause concern heightening anxiety and may require evaluation/treatment.

Cognitive restructuring corrects misconceptions and develops self-confidence.

Collaborative

Administer medication as indicated:

Antianxiety agents, e.g., alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin);

Antidepressants, e.g., imipramine (Tofranil), desipramine (Norpramin); or selective serotonin reuptake inhibitors (SSRIs), e.g., fluoxetine (Prozac), sertraline (Zoloft);

Monoamine-oxidase inhibitors (MAOIs), e.g., phenelzine sulfate (Nardil);

Propranolol (Inderal);

Anticonvulsants, e.g., valproate (Depakene), carbamazepine (Tegretol).

Refer client/family to counseling, psychotherapy, or groups, as indicated.

Provides relief from the immobilizing effects of anxiety and promotes participation in ADLs and therapy program. Drug effects may be noted shortly after beginning therapy but problems with dependence/withdrawal symptoms may occur.

May be used in conjunction with other drugs as antidepressants may require several weeks before positive effects are noted, and still may not alter client's *fear* of panic attacks. SSRIs have fewer/milder side effects and may be better tolerated by client. **Note:** Upwards of 50% of client's with panic disorder also have an episode of major depression.

These drugs have also been found to be effective in treating panic attacks. Side effects may be temporary, and caution needs to be exercised about food that should not be consumed while receiving these drugs.

Several antihypertensive agents such as this beta blocker have potent effects on the somatic manifestations of anxiety (e.g., palpitations, tremors, etc.), although they have less dramatic effects on the psychological component of anxiety.

These drugs have a sedative effect on the CNS and are used to stabilize mood in some clients, especially when other drugs are ineffective.

May need additional assistance/long-term support to make lifestyle changes necessary to achieve maximum recovery.