Anxiety disorders
Anxiety Disorders

a group of conditions where the primary symptoms are anxiety or defenses against anxiety. the patient fears something awful will happen to them.
What is anxiety?

- is a state of intense apprehension, uneasiness, uncertainty, or fear.
Introduction

• Anxiety: emotional response
• Stress: stressors
• Anxiety disorders are the most common of all psychiatric illnesses and result in considerable functional impairment and distress
• more common in women than in men, in a ratio of at least 2 to 1
Introduction

• Epidemiological studies suggest that the symptoms are more prevalent among girls than boys
• children in minority groups and children from low socioeconomic environments may be at greater risk for all emotional illness
Types of anxiety disorder

- Generalized anxiety disorder
- Panic attacks and panic disorder
- Phobias
- Obsessive compulsive disorder (OCD)
Panic disorder

- **Panic**: A sudden overwhelming feeling of terror or impending doom.
- most severe form of emotional anxiety is usually accompanied by behavioral, cognitive, and physiological signs and symptoms considered to be outside the expected range of normalcy.
- Panic attack: unexpected
- The attacks usually last minutes, or more rarely, hours.
- The individual often experiences varying degrees of nervousness and apprehension between attacks.
- The average age of onset of panic disorder is the late 20s.
- may last for a few weeks or months or for a number of years.
- periods of remission and exacerbation.
- Panic disorder may or may not be accompanied by agoraphobia

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At least four of the following symptoms must be present to identify the presence of a panic attack.

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias (numbness or tingling sensations)
- Chills or hot flashes
Panic Disorder with Agoraphobia

- characterized by the symptoms of panic disorder.
- In addition, experiences a fear of being in places or situations from which escape might be difficult
  - or embarrassing
  - or in which help might not be available in the event that a panic attack should occur
- This fear severely restricts travel
- the individual may become nearly or completely housebound or unable to leave the house unaccompanied.
- Common agoraphobic situations include:
  - being outside the home alone
  - being in a crowd or standing in a line
  - being on a bridge
  - traveling in a bus, train, or car
Generalized Anxiety Disorder

- An anxiety disorder in which a person is continuously tense, apprehensive and in a state of autonomic nervous system arousal.

The patient is constantly tense and worried, feels inadequate, is oversensitive, can't concentrate and suffers from insomnia.
• The disorder may begin in childhood or adolescence,
• onset is not uncommon after age 20.
• Depressive symptoms are common
• numerous somatic complaints may also be a part of the clinical picture.
• Generalized anxiety disorder tends to be chronic
• frequent stress-related exacerbations and fluctuations in the course of the illness may occur.
S/S

- The symptoms must have occurred more days than not
- For at least 6 months
- must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
S/S

- Excessive anxiety and worry about a number of events that the individual finds difficult to control
- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind “going blank”
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

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Etiological Implications for Panic and Generalized Anxiety Disorders

- **Psychodynamic Theory**: inability of the ego to intervene when conflict occurs between the id and the superego, producing anxiety.

- **Cognitive Theory**: When there is a disturbance in this central mechanism of cognition, there is a consequent disturbance in feeling and behavior.
• **Biological Aspects:**
  – **Genetics:** Panic disorder has a strong genetic element

• **NEUROANATOMICAL.**
  – lower brain centers, including the limbic system, the diencephalon (thalamus and hypothalamus), and the reticular formation.
  – Structural brain imaging studies implicated pathological involvement in the temporal lobes, particularly the hippocampus
• **BIOCHEMICAL:**
  – Abnormal elevations of blood lactate
  – infusion of sodium lactate into clients with anxiety neuroses produced symptoms of panic disorder.

• **NEUROCHEMICAL:**
  – Norepinephrine
  – it is known that norepinephrine mediate arousal, and it causes hyperarousal and anxiety.
  – This fact has been demonstrated by a notable increase in anxiety following the administration of drugs that increase the synaptic availability of norepinephrine, such as yohimbine (Figure 17–1).
• **Medical Conditions**
  
  – Abnormalities in the hypothalamic–pituitary–adrenal and hypothalamic–pituitary–thyroid axes
  – Acute myocardial infarction
  – Pheochromocytomas
  – Substance intoxication and withdrawal (cocaine, alcohol, marijuana, opioids)
  – Hypoglycemia
  – Caffeine intoxication
  – Mitral valve prolapse
  – Complex partial seizures
Nursing Diagnosis

• Panic anxiety related to real or perceived threat to biological integrity or self-concept evidenced by any or all of the physical symptoms identified by the *DSM-IV-TR* as being descriptive of panic or generalized anxiety disorder.

• Powerlessness related to impaired cognition evidenced by verbal expressions of no control over life situation and nonparticipation in decision-making related to own care or life situation.
Outcome

• Is able to recognize signs of escalating anxiety.
• Is able to intervene so that anxiety does not reach the panic level.
• Is able to discuss long-term plan to prevent panic anxiety when stressful situation occurs.
Planning/Implementation

- Table 17–1
Phobias

• A person experiences sudden episodes of intense dread.
Phobia

- *Fear* cued by the presence or anticipation of a specific object or situation, exposure to which almost invariably provokes an immediate *anxiety* response or *panic attack* even though the subject recognizes that the fear is excessive or unreasonable.

- The phobic stimulus is avoided or endured with marked distress.
Agoraphobia Without History of Panic Disorder

- fear of being in places or situations from which escape might be difficult, or in which help might not be available if a limited-symptom attack or panic-like symptoms (rather than full panic attacks) should occur
- Onset of symptoms 20s and 30s and persists for many years.
- more commonly in women than in men
- Impairment can be severe.
- In extreme cases the individual is unable to leave his or her home without being accompanied by a friend or relative.
- If this is not possible the person may become totally confined to his or her home.
Box 17 – 1 Diagnostic Criteria for Agoraphobia Without History of Panic Disorder

A. The presence of agoraphobia related to fear of developing panic-like symptoms. Agoraphobia is the fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of suddenly developing a symptom(s) that could be incapacitating or extremely embarrassing. Examples include dizziness or falling, depersonalization or derealization, loss of bladder or bowel control, vomiting, or cardiac distress. As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car.

B. Criteria for panic disorder have never been met.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

D. If an associated general medical condition is present, the fear is clearly in excess of that usually associated with the condition.
Social Phobia

• an excessive fear of situations in which a person might do something embarrassing or be evaluated negatively by others.

• The individual has extreme concerns about being exposed to possible scrutiny by others and fears social or performance situations in which embarrassment may occur
Examples

• Fear of speaking or eating in a public place, fear of using a public restroom, or fear of writing in the presence of others.
• In other cases, the social phobia may involve general social situations, such as saying things or answering questions in a manner that would provoke laughter on the part of others.
• Exposure to the phobic situation usually results in feelings of panic anxiety, with sweating, tachycardia, and dyspnea.
Onset of symptoms of this disorder often begins in late childhood or early adolescence and runs a chronic, sometimes lifelong, course.

It appears to be equally common among men and women.

Impairment interferes with social or occupational functioning, or causes marked distress.
A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

**NOTE:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack.

**NOTE:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable.

**NOTE:** In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person’s normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals younger than 18 years of age, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).

H. If a general medical condition or another mental disorder is present, the fear in criterion A is unrelated to it (e.g., the fear is not of stuttering, trembling in Parkinson’s disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).

The diagnosis is further specified as **generalized** if the fears include most social situations.
Specific Phobia

- formerly called simple phobia.
- The essential feature of this disorder is a marked, persistent, and excessive or unreasonable fear when in the presence of, or when anticipating an encounter with, a specific object or situation.
- Specific phobias frequently occur concurrently with other anxiety disorders, but are rarely the focus of clinical attention in these situations.
- Treatment is generally aimed at the primary diagnosis because it usually produces the greatest distress and interferes with functioning more so than does a specific phobia.
<table>
<thead>
<tr>
<th>Classification</th>
<th>Fear</th>
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<tbody>
<tr>
<td>Acrophobia</td>
<td>Height</td>
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<tr>
<td>Ailurophobia</td>
<td>Cats</td>
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<tr>
<td>Algophobia</td>
<td>Pain</td>
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<td>Anthophobia</td>
<td>Flowers</td>
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<tr>
<td>Anthropophobia</td>
<td>People</td>
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<tr>
<td>Aquaphobia</td>
<td>Water</td>
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<td>Arachnophobia</td>
<td>Spiders</td>
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<tr>
<td>Astraphobia</td>
<td>Lightning</td>
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<td>Belonephobia</td>
<td>Needles</td>
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<td>Brontophobia</td>
<td>Thunder</td>
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<tr>
<td>Claustrophobia</td>
<td>Closed spaces</td>
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<tr>
<td>Cynophobia</td>
<td>Dogs</td>
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<td>Dementophobia</td>
<td>Insanity</td>
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<td>Equinophobia</td>
<td>Horses</td>
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<tr>
<td>Gamophobia</td>
<td>Marriage</td>
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<tr>
<td>Herpetophobia</td>
<td>Lizards, reptiles</td>
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<td>Homophobia</td>
<td>Homosexuality</td>
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<tr>
<td>Murophobia</td>
<td>Mice</td>
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<tr>
<td>Mysophobia</td>
<td>Dirt, germs, contamination</td>
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<tr>
<td>Numerophobia</td>
<td>Numbers</td>
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<tr>
<td>Nyctophobia</td>
<td>Darkness</td>
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<td>Ochophobia</td>
<td>Riding in a car</td>
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<td>Ophidiophobia</td>
<td>Snakes</td>
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<td>Pyrophobia</td>
<td>Fire</td>
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<tr>
<td>Scoleciphobia</td>
<td>Worms</td>
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<tr>
<td>Siderodromophobia</td>
<td>Railroads or train travel</td>
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<tr>
<td>Taphophobia</td>
<td>Being buried alive</td>
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<td>Thanatophobia</td>
<td>Death</td>
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<tr>
<td>Trichophobia</td>
<td>Hair</td>
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<td>Triskaidekaphobia</td>
<td>The number 13</td>
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<tr>
<td>Xenophobia</td>
<td>Strangers</td>
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<tr>
<td>Zoophobia</td>
<td>Animals</td>
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</tbody>
</table>
Box 17–3 Diagnostic Criteria for Specific Phobia

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. NOTE: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

C. The person recognizes that the fear is excessive or unreasonable. 
NOTE: In children, this feature may be absent.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person’s normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under 18 years, the duration is at least 6 months.

G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder.

The diagnosis may be further specified as:

- Animal type
- Natural environment type (e.g., heights, storms, water)
- Blood-injection-injury type
- Situational type (e.g., airplanes, elevators, enclosed places)
- Other type
The *DSM-IV-TR* identifies subtypes of the most common specific phobias:

- **Animal type**
- **Natural environment type:** such as heights, storms, or water.
- **Blood-injection-injury type**
- **Situational type:** public transportation, tunnels, bridges, elevators, flying, driving, or enclosed places.
- **Other type:** all other excessive or irrational fears. It may include fear of contracting a serious illness, fear of situations that might lead to vomiting or choking, fear of loud noises, or fear of driving.
Etiological Implications for Phobias

• *Psychoanalytical Theory:* Freud believed that phobias develop when a child experiences normal incestuous feelings toward the opposite-sex parent (Oedipal/Electra complex) and fears aggression from the same-sex parent (castration anxiety).
• **Learning Theory:** Classic conditioning in the case of phobias may be explained as follows: a stressful stimulus produces an “unconditioned” response of fear.
• **Cognitive Theory:** Cognitive theorists espouse that anxiety is the product of faulty cognitions or anxiety-inducing self-instructions.

• Two types of faulty thinking have been investigated: negative self-statements and irrational beliefs.
• **Biological Aspects**
  
  – **TEMPERAMENT.** Children experience fears as a part of normal development. Most infants are afraid of loud noises.
  
  – Common fears of toddlers and preschoolers include strangers, animals, darkness, and being separated from parents or attachment figures.
  
  – During the school age years, there is fear of death and anxiety about school achievement. Fears of social rejection and sexual anxieties are common among adolescents.
• **LIFE EXPERIENCES:** (e.g., death of a significant other; interpersonal conflict)
  – A child who is punished by being locked in a closet develops a phobia for elevators or other closed places.
  – A child who falls down a flight of stairs develops a phobia for high places.
  – A young woman who, as a child, survived a plane crash in which both her parents were killed has a phobia of airplanes.
Nursing Diagnosis

• Fear related to causing embarrassment to self in front of others; to being in a place from which one is unable to escape; or to a specific stimulus, evidenced by behavior directed toward avoidance of the feared object or situation.

• Social isolation related to fears of being in a place from which one is unable to escape, evidenced by staying alone, refusing to leave room or home.
Outcome

• Functions adaptively in the presence of the phobic object or situation without experiencing panic anxiety.
• Demonstrates techniques that can be used to maintain anxiety at a manageable level.
• Voluntarily attends group activities and interacts with peers.
Planning/Implementation

• Table 17–3
Evaluation
Obsessive Compulsive Disorder

- An anxiety disorder characterized by unwanted repetitive thoughts (obsessions) and/or actions (compulsions).
Obsessions

• Unwanted, intrusive, persistent ideas, thoughts, impulses, or images that cause marked anxiety or distress.

• The most common ones include repeated thoughts about contamination, repeated doubts, a need to have things in a particular order, aggressive or horrific impulses, and sexual imagery.
Compulsions

• Unwanted repetitive behavior patterns or mental acts (e.g., praying, counting, repeating words silently) that are intended to reduce anxiety, not to provide pleasure or gratification (APA, 2000).

• They may be performed in response to an obsession or in a stereotyped fashion.
## Common Examples of OCD

<table>
<thead>
<tr>
<th>Common Obsessions:</th>
<th>Common Compulsions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination fears of germs, dirt, etc.</td>
<td>Washing</td>
</tr>
<tr>
<td>Imagining having harmed self or others</td>
<td>Repeating</td>
</tr>
<tr>
<td>Imagining losing control of aggressive urges</td>
<td>Checking</td>
</tr>
<tr>
<td>Intrusive sexual thoughts or urges</td>
<td>Touching</td>
</tr>
<tr>
<td>Excessive religious or moral doubt</td>
<td>Counting</td>
</tr>
<tr>
<td>Forbidden thoughts</td>
<td>Ordering/arranging</td>
</tr>
<tr>
<td>A need to have things “just so”</td>
<td>Hoarding or saving</td>
</tr>
<tr>
<td>A need to tell, ask, confess</td>
<td>Praying</td>
</tr>
</tbody>
</table>

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Box 17-4 Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:
   *Obsessions as defined by 1, 2, 3, and 4:*
   1. Recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance as intrusive and inappropriate and that cause marked anxiety or distress.
   2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
   3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
   4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

   *Compulsions as defined by 1 and 2:*
   1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
   2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way
   with what they are designed to neutralize or prevent or are clearly excessive.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **NOTE:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hr a day), or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder; hair pulling in the presence of trichotillomania; concern with appearance in the presence of body dysmorphic disorder; preoccupation with having a serious illness in the presence of hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a paraphilia; or guilty ruminations in the presence of major depressive disorder).

E. This disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.
Etiological Implications for Obsessive–Compulsive Disorder

• *Psychoanalytical Theory*
  – individuals with OCD have weak, underdeveloped egos (for any of a variety of reasons: unsatisfactory parent-child relationship, conditional love, or provisional gratification).
  – The psychoanalytical concept views clients with OCD as having regressed to earlier developmental stages of the infantile superego—the harsh, exacting, punitive characteristics that now reappear as part of the psychopathology.
• **Learning Theory:** conditioned response to a traumatic event.

  – The traumatic event produces anxiety and discomfort, and the individual learns to prevent the anxiety and discomfort by avoiding the situation with which they are associated (*passive avoidance*) (staying away from the source).

  – When passive avoidance is not possible, the individual learns to engage in behaviors that provide relief from the anxiety and discomfort associated with the traumatic situation (*active avoidance*)
• **Biological Aspects:** neurobiological disturbances may play a role in the pathogenesis and maintenance of OCD.

• **NEUROANATOMY.** Abnormalities in various regions of the brain have been implicated in the neurobiology of OCD.
  – abnormal metabolic rates in the basal ganglia and orbital frontal cortex of individuals with the disorder
• **PHYSIOLOGY.** Electrophysiological studies, sleep electroencephalogram studies, and neuroendocrine studies have suggested that there are commonalities between depressive disorders and OCD.

  - Neuroendocrine commonalities were suggested in studies in which about one-third of OCD clients show non-suppression on the dexamethasone suppression test and decreased growth hormone secretion with clonidine infusions.
• **BIOCHEMICAL**: neurotransmitter serotonin as influential in the etiology of obsessive–compulsive behaviors.
  – Drugs that have been used successfully in alleviating the symptoms of OCD are clomipramine and the selective serotonin reuptake inhibitors (SSRIs), all of which are believed to block the neuronal reuptake of serotonin, thereby potentiating serotoninergic activity in the central nervous system
Nursing Diagnosis

• Ineffective coping related to underdeveloped ego, punitive superego; avoidance learning; possible biochemical changes evidenced by ritualistic behavior and/or obsessive thoughts.

• Ineffective role performance related to need to perform rituals evidenced by inability to fulfill usual patterns of responsibility.
• Outcome
• Planning/Implementation: Table 17–4
• Evaluation
Post Traumatic Stress Disorder (PTSD)

- Patients with PTSD have experienced a trauma and develop disabling symptoms in response to the event.
- Symptoms usually begin within 3 months of the trauma
- Syndrome can occur at any age
Definition of Trauma

- The person experienced, witnessed or learned of an event that involved actual or threatened death, serious injury, or threat of harm to self or others

- The person’s response involved intense fear, helplessness or horror
Types of Trauma

- Sexual abuse
- Rape
- Physical abuse
- Severe motor vehicle accidents
- Robbery/mugging
- Terrorist attack
- Combat veteran
- Natural disasters

- Being diagnosed with a life threatening illness
- Sudden unexpected death of family/friend
- Witnessing violence (including domestic violence)
- Learning one’s child has life threatening illness
Diagnosis of PTSD

• Symptoms must be ≥ one month duration and include:
  – Re-experiencing symptoms
  – Avoidance symptoms
  – Emotional numbing
  – Hyperarousal symptoms
Re-experiencing Symptoms

• There are recurrent, intrusive thoughts of the event (can’t not think about it)
• Dreams (nightmares) about the event
• Acting or feeling the event is recurring, or sense of living the event (flashbacks)
• Psychological or Physiological Distress upon exposure to reminders or cues of the event.
Avoidance/Numbing Symptoms

- Avoid thoughts, feelings, places or people that arouse memories of the event
- Being unable to recall important parts of the event
- Decrease interest in activities
- Feeling detached or estranged from others
- Decreased range of affect
- Sense of foreshortened future
Hyperarousal Symptoms

• Patient experiences at least two of the following:
  – Insomnia (falling or staying asleep)
  – Irritability or outbursts of anger
  – Decreased concentration
  – Hypervigilance
  – Increased/exaggerated startle response
Epidemiology of PTSD

- Prevalence is 1% in the general population, and can be as high as 25% in those who have experienced trauma.
- Very high prevalence in women who are victims of sexual trauma.
Psychosocial Theory

• The traumatic experience
  – Severity and duration of the stressor
  – Degree of anticipatory preparation for the event
  – Exposure to death
  – Numbers affected by life threat
  – Amount of control over recurrence
  – Location where the trauma was experienced (e.g., familiar surroundings, at home, in a foreign country)
• The individual
  – Degree of ego strength
  – Effectiveness of coping resources
  – Presence of pre-existing psychopathology
  – Outcomes of previous experiences with stress/trauma
  – Behavioral tendencies (temperament)
  – Current psychosocial developmental stage
  – Demographic factors (e.g., age, socioeconomic status, education)
• The recovery environment
  – Availability of social supports
  – The cohesiveness and protectiveness of family and friends
  – The attitudes of society regarding the experience
  – Cultural and subcultural influences
• Learning theory
• Cognitive theory
• Biological aspects
Nursing Diagnosis

• Posttrauma syndrome related to distressing event considered to be outside the range of usual human experience evidenced by flashbacks, intrusive recollections, nightmares, psychological numbness related to the event, dissociation, or amnesia.

• Complicated grieving related to loss of self as perceived before the trauma or other actual or perceived losses incurred during or after the event evidenced by irritability and explosiveness, self-destructiveness, substance abuse, verbalization of survival

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Planning/Implementation

- Table 17–5
Anxiety Disorder Due to a General Medical Condition

- Endocrine conditions: Hyperthyroidism and hypothyroidism, pheochromocytoma, hypoglycemia, hyperadrenocorticism
- Cardiovascular conditions: Congestive heart failure, pulmonary embolism, arrhythmia
- Respiratory conditions: Chronic obstructive pulmonary disease, pneumonia, hyperventilation
- Metabolic conditions: Vitamin B12 deficiency, porphyria
- Neurological conditions: Neoplasms, vestibular dysfunction, encephalitis
Substance-Induced Anxiety Disorder

• Nursing care of the client with substance-induced anxiety disorder must take into consideration the nature of the substance and the context in which the symptoms occur; that is, intoxication or withdrawal
Treatment modalities

- **Individual Psychotherapy**
- **Cognitive therapy**
- **Group/Family therapy**
- **Behavioral therapy**
  - **Systematic Desensitization**: Systematic desensitization with reciprocal inhibition involves two main elements:
    - Training in relaxation techniques
    - Progressive exposure to a hierarchy of fear stimuli while in the relaxed state.
  - **Implosion Therapy (Flooding)**: Therapeutic process in which the client must imagine situations or participate in real-life situations that he or she finds extremely frightening, for a prolonged period of time. Relaxation training is not a part of this technique.
Psychopharmacology

• For Panic and Generalized Anxiety Disorders

• Anxiolytics:
  – Benzodiazepines: treatment of generalized anxiety disorder.
  – Alprazolam, lorazepam, and clonazepam have been particularly effective in the treatment of panic disorder.
  – The major risks with benzodiazepine therapy are physical dependence and tolerance, which may encourage abuse.
  – Because withdrawal symptoms can be life-threatening, clients must be warned against abrupt discontinuation of the drug and should be tapered off the medication at the end of therapy.
  – buspirone (Buspar) is effective in about 60 to 80 percent of clients with generalized anxiety disorder. Adv: lack of physical dependence make it the drug of choice in the treatment of generalized anxiety disorder.
• **Antidepressants**
  
  – The tricyclics clomipramine and imipramine have been used with success in clients experiencing panic disorder.
  – However, since the advent of SSRIs, the tricyclics are less widely used because of their tendency to produce severe side effects at the high doses required to relieve symptoms of panic disorder.
  – The SSRIs have been effective in the treatment of panic disorder: e.g. Paroxetine, fluoxetine, and sertraline.
• **Antihypertensive Agents**
  – beta-blockers (e.g., propranolol) and alpha2-receptor agonists (e.g., clonidine) in the amelioration of anxiety symptoms
  – Clonidined is effective in blocking the acute anxiety effects in conditions such as opioid and nicotine withdrawal: tolerance and addict
For Phobic Disorders

- Anxiolytics
- Antidepressant
- Antihypertensive agents
For Obsessive–Compulsive Disorder

• *Antidepressants*
For Posttraumatic Stress Disorder

• Antidepressants
• Anxiolytic
• Antihypertensive
• Other Drugs: Carbamazepine, valproic acid, and lithium carbonate have been reported to alleviate symptoms of intrusive recollections, flashbacks, nightmares, impulsivity, irritability, and violent behavior in PTSD clients.
PTSD Treatment

• Psychotherapies
  – Exposure-based cognitive behavioral therapy
  – Psychotherapy aimed at survivor anger, guilt and helplessness (victimization)

• Pharmacological treatment targets the reduction of prominent symptoms
  – SSRI’s are first line therapy
  – Atypical antipsychotics are being increasingly used