

WHAT IS ANXIETY?

Anxiety is an emotion characterized by feelings of tension, worried thoughts, and various physical changes. Anxiety can occur as a natural response to suffering, uncertainty, illness, and many other factors. Those with chronic anxiety disorders usually have recurring intrusive thoughts and worries, which can cause significant problems in all aspects of a patient's life.

Common causes of anxiety in hospice and palliative care patients include diagnosis of a serious illness, disease progression, loss of independence, symptom burden, financial concerns, existential distress, anticipatory grief, and uncertainty about the future.

SIGNS & SYMPTOMS

- Increased blood pressure, chest pain, shortness of breath
- Feelings of restlessness, tension, irritability, fatigue, worry, panic, inability to concentrate, and increased distractibility
- Muscular tension, headaches
- Sleep disruption such as insomnia, restlessness, or non-restorative sleep
- Concomitant presence of depression

INTERVENTIONS

Clinical assessment should include comprehensive nursing history and careful physical exam, including history of anxiety (onset, qualities, associated symptoms, precipitating and relieving events, and response to medications), along with psychosocial and medication history, with review of laboratory and diagnostic test results.

- Identify the underlying etiology and stage of illness. Review the goals of care with the patient and family. Discuss the benefits and burdens of treatment options.
- It is especially important to assess for concomitant depression in order to tailor interventions accordingly (e.g., medications, psychotherapy, counseling).
- Assess anxiety with a validated tool such as the Generalized Anxiety Disorder seven-item scale (GAD-7). The State-Trait Anxiety Inventory (STAI) and the Fear of Disease Progression Scale have also been used in cancer settings to screen for anxiety.¹
- In advanced illness, if culturally appropriate, discuss shifting goals of care to reduce symptom burden and improve the patient's coping skills when treatment optimization for the underlying etiology is not achievable.
- Continue ongoing monitoring of anxiety, response to therapeutic interventions, and overall impact on functional status.

NONPHARMACOLOGICAL INTERVENTIONS	PHARMACOLOGICAL INTERVENTIONS
<ul style="list-style-type: none"> • Be self-aware of any personal anxiety reflected in your approach. • Maintain eye contact, relaxed body language, and calm tone of voice. • Keep words and phrases simple to minimize stimulation. • Use open-ended questions to elicit underlying feelings rather than simple “yes” or “no” answers. • Include the patient in decision-making to enhance feelings of control. • Utilize teach-back techniques to reinforce management strategies and empower the patient’s understanding of next steps. • Use the team to teach or reinforce complementary or alternative relaxation techniques, such as guided imagery, aromatherapy, art and music therapies, massage, prayer, and meditation. 	<p>Optimize treatment of underlying etiologies and manage any other uncontrolled symptoms such as dyspnea or pain. Treatment of anxiety is warranted if it is causing significant distress or affecting the patient’s quality of life. Individualize treatment with consideration of the patient’s overall medical condition and prognosis.</p> <p>Begin with the lowest dose possible and titrate carefully to desired effect. Taper if adverse effects occur.</p> <p>Opioids are indicated for the treatment of anxiety related to dyspnea at the end of life.⁴</p> <p>Anxiolytics commonly used for acute anxiety may include:</p> <ul style="list-style-type: none"> • Benzodiazepines (lorazepam, alprazolam) • Antihistamines (diphenhydramine) • Carbamate derivatives (meprobamate) • Azaspirodecanedione (buspirone) (delayed onset of effect) • Haloperidol (Consider if titration of lorazepam is ineffective. Baseline electrocardiogram is an important consideration, as intravenous haloperidol lactate can lead to prolonged QT syndrome.)

Clinical alert:

Benzodiazepines are toxic if overdosed, can suppress respirations, may cause cognitive impairment, have a risk for abuse and addiction, and can have a paradoxical effect in older adults and worsen anxiety.⁴

If a patient cannot tolerate benzodiazepines or they do not affect anxiety, consider a low-dose antipsychotic medication. Olanzapine and quetiapine are effective with severe anxiety and do not cause the respiratory depression that benzodiazepines can.⁴

Common side effects of anxiolytics include:

- Drowsiness, confusion, lethargy
- Tolerance
- Dry mouth
- Orthostatic hypotension
- Nausea and vomiting
- Blood dyscrasia

Note:

Chronic anxiety (anxiety disorder) requires various treatment modalities, including psychotherapy, integrative therapies, and pharmacotherapy, which may include serotonin-reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). In the presence of concurrent depression, antidepressants and psychostimulants may also be added to the medication regimen in conjunction with the other therapeutic interventions listed.

FAMILY & TEAM DISCUSSIONS

- Clarify patient and family goals frequently during the course of illness.
- Discuss anxiety with the patient and family, focusing on its effects on the patient's functional status, quality of life, and caregiver burden.
- Provide education about signs of anxiety and awareness of triggers, available treatment options, medications, and anticipated side effects.
- Explore realistic expectations for symptom trajectory, with reassuring education on interventional strategies.
- Provide instructions on medication management and equip families to utilize appropriate nonpharmacological strategies.

Interprofessional Team:

Patients with anxiety benefit from multiple perspectives for successful interventions to address physical, social, psychological, and spiritual aspects of care. Consider social work, counseling, and spiritual care consultations to address related concerns, such as spiritual, cultural, and financial issues.

SYMPTOM DOCUMENTATION EXAMPLE

1. **67 yr old female hospice patient with stage 4 metastatic breast cancer** reports “panic attacks” related to increasing pain. States, “Pain medicine helps a lot, but I’m still so afraid that it won’t stop.” Reports pain is mainly controlled but has feelings of fear escalating to panic, along with recent insomnia and inability to concentrate. Also reveals concerns related to financial issues and her husband’s ability to continue being her primary caregiver. Review

current pain regimen. Explain benefit of anxiolytic medication to alleviate immediate distress. Offer social work support to address psychosocial concerns. Patient agrees to trial of lorazepam for acute anxiety and welcomes additional team support.

- 2. 59 yr old male palliative patient with chronic obstructive pulmonary disease** diagnosed two years ago reports increasing dyspnea and accompanying anxiety when “I can’t catch my breath.” Using O₂ @ 2L per nasal cannula as needed and at night. Continues his inhaled and nebulized medications as ordered. States immediate-release morphine provides some relief. Demonstrate guided imagery, relaxation techniques, and pursed-lip breathing to patient and caregiver with successful return demonstration. Discuss use of music to enhance comfort. Patient expresses hopefulness that he could “manage better” using those tools for symptom control. Plan to follow-up via phone call within 48 hours to evaluate status. Reinforce with patient and caregiver 24-hour contact availability for worsening symptoms and/or clarifications to revised plan of care.

DESIRED NURSING OUTCOMES

- Promote optimal comfort and symptom control.
- Maximize functional status and quality of life for patient and family as the patient’s illness progresses.
- As patient declines, revisit goals of care and have discussions frequently. Document the discussions and ensure decision-makers are aware of patient’s care preferences.

REFERENCES

1. Salman J, Wolfe J, Patel SK. Anxiety and depression. In: Ferrell B, Paice J, eds. *Oxford Textbook of Palliative Nursing*. 5th ed. New York, NY: Oxford University Press; 2019.
2. Gatto M, Thomas P, Berger A. Anxiety. In: Dahlin C, Coyne F, Ferrell B, eds. *Clinical Pocket Guide to Advanced Practice Palliative Nursing*. New York, NY: Oxford University Press; 2017.