CLiP

15 minute Worksheet

15 min

Psychological needs

4: Helping the anxious person

Intermediate level

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Aim of this worksheet
To understand the principles of helping the anxious person

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, and then turn to the Work page overleaf.
- Work any way you want. You can start with the exercises on the Work page using your own knowledge. The answers are on the Information page - this is not cheating since you learn as you find the information. Alternatively you may prefer to start by reading the Information page before moving to the exercises on the Work page.
- This CLiP worksheet should take about 15 minutes to complete, but will take longer if you are working with colleagues or in a group. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know.
- Take this learning into your workplace using the activity on the back page.

Case Study

Peter is a 46 year old man, married with two children. He initially complained of increasing weakness in his legs. Always an anxious man, at first this was put down to stress. When the weakness worsened, however, investigations and examination by the neurologist suggested motor neurone disease, and subsequent progression of the signs and symptoms has confirmed the diagnosis. He wanted to know the diagnosis and was told.

Today he comes to see you. He is fidgety, unsettled and seems anxious.

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INFORMATION PAGE: Helping the anxious person

Getting started

- **Acknowledge what is happening.** This first step applies to many situations. Simply reflect back what is happening eg. "You seem anxious today. How can I help?." While this may seem unnecessary, it gives Peter a clear message that you have noticed his anxiety and that you are taking it seriously.
- **Negotiate further discussion**, eg. "Can we talk about how you're feeling?"

Mimics of anxiety

1. Some drugs can produce restlessness. This is unrelated to anxiety but can mimic the motor tension aspects of anxiety. Drugs which may cause this are cyclizine, haloperidol, hyoscine, levomepromazine (methotrimeprazine), metoclopramide, and the tricyclic antidepressants (eg. amitriptyline). The differentiating feature is that patients may deny any severe anxiety, although sometimes anxiety is part of the drug effect. A single drug alone is an unusual cause unless higher doses are being used, or the patient is very young or elderly. The risk is much greater when two or more at-risk drugs are used together and this risk can be reduced by avoiding combinations of drugs with this effect.
2. Confusional states can make a patient hyperalert and restless.
3. Pain that is not worsened by movement can make some patients restless, mainly as a distractive behaviour.

The features of anxiety

Life-threatening illness creates an uncertain future that causes anxiety which may increase as the illness progresses. Anxiety in turn makes it more difficult for the patient to cope with suffering. Features of anxiety are:

- *Thinking*: tendency to perceive situations (including bodily sensations) in a distorted and/or threatening way.
- *Emotional:* includes apprehension, fear, terror, irritability, lowered mood.
- *Physiological:* motor features (e.g. trembling, tension, restlessness) and autonomic features (e.g. insomnia, loss of appetite, sweating, dry mouth, cold hands, tachycardia, and diarrhoea).
- *Behavioural:* avoidance, checking, compulsions (all of which can maintain and exacerbate anxiety).

In advanced disease, anxiety is often associated with depression. The Hospital Anxiety and Depression (HAD) scale is a sensitive and specific tool for generalised anxiety which can also help in identifying accompanying depression, although it is less specific for depression in advanced disease.

Supportive measures

Expression: enabling Peter to express his feelings and giving the information he needs can do much to ease anxiety. You could ask Peter if he has suffered from anxiety in the past and, if so, what helped him deal with it? What you are trying to do is ascertain what resources he has already to cope with his anxiety.

Cognitive behavioural therapy (CBT): helping Peter to identify links between his thoughts, feelings and behaviour and to then generate alternative interpretations or ways of coping can also help. For example, an alternative thought to 'I feel out of control with all this machinery' would be 'The technology is there to help and this comforts me.' Similar approaches have been used with visualisation. CBT can result in rapid relief of anxiety.

Anxiety management techniques can be helpful such as distraction or relaxation. Muscle relaxation techniques are best avoided as it can worsen the anxiety of some people who are excessively vigilant of their bodily sensations, and relaxation using visualisation or music are better alternatives.

Complementary therapy: it helps to have access to massage or aromatherapy. Reflexology has a role if the therapist is willing to pass any interpretations they make to the professional and not to the patient (telling an anxious person the reflexologist 'felt something wrong' will worsen their anxiety).

Identifying and managing difficult problems

Anxiety state: this is defined as a mood different to, or worse than, their usual mood and by a persistent anxiety for >50% of the time and for >2 weeks, together with four or more features of anxiety

Disorganisation: this may be mild with very poor concentration and can be eased with supportive measures, perhaps with the short-term use of mild benzodiazepines such as lorazepam. Occasionally the disorganisation is severe (tormented, unable to care for themselves or unable to make a decision) and this will usually need an antipsychotic (haloperidol or levomepromazine) and referral to a psychiatrist.

Somatic symptoms ie. autonomic hyperactivity such as sweating and tremor, can be helped with drugs such as propranolol.

Panics and phobias: feelings of impending doom suggest a panic or phobia. Cognitive behavioural therapy seeks out triggers and explores thoughts and can be helpful with panics and phobias. Cognitive behavioural therapy (CBT) can help individuals to manage and overcome panic and phobias (see supportive measures). Drugs such as citalopram or lorazepam can also help.

Depression: depression commonly accompanies anxiety and patients may be feeling hopeless and apathetic. It is common to miss depression because of the more obvious anxiety symptoms. See CLiP worksheet, *Helping the Withdrawn Patient.*

If features of anxiety persist or are severe, ask for specialist help.

First aid for a panic attack It can be a little scary if you have not seen it before. Exclude any medical emergency, then calmly reassure the person that this is a panic, not a physical crisis. If they start to complain of tingling or numb fingers, look for a paper bag or something similar for them to breathe into. Stay with them until the attack subsides. If the person is too agitated to do this, walk with them until they feel ready to talk further.

Think about what might cause restlessness <u>other</u> than anxiety

Make a list of the features of anxiety in the following categories:

Thinking features	**Motor features**
Coping features	**Autonomic features**

Write a list of supportive measures that might help Peter

Consider which of these would make you concerned about Peter 's anxiety

Persistent anxiety for the past two weeks

Unable to decide what to eat

Feelings of impending doom

Sweating and tremor

Occasional forgetfulness

Not bothering to shave or wash

Looking anxious

Feeling hopeless and apathetic

How could you help Peter if he had a panic attack?

FURTHER ACTIVITY: Helping the anxious person

Reflect on times when you were anxious.

- What helped or hindered you in dealing with it?
- Do you know how to deal with an acute panic attack if a patient or relative has one?

FURTHER READING: Helping the anxious person

Journal articles

Anderson T. Watson M. Davidson R. The use of cognitive behavioural therapy techniques for anxiety and depression in hospice patients: a feasibility study. *Palliative Medicine*. 2008, **22**(7): 814-21.

Burns SJ. Harbuz MS. Hucklebridge F. Bunt L. A pilot study into the therapeutic effects of music therapy at a cancer help center. *Alternative Therapies in Health & Medicine.* 2001; **7**(1): 48-56.

Brittlebank A, Regnard C. Terror or depression? A case report. *Palliative Medicine* 1990; **4**: 317 - 319

Grov EK. Dahl AA. Moum T. Fossa SD. Anxiety, depression, and quality of life in caregivers of patients with cancer in late palliative phase. *Annals of Oncology.* 2005, **16**(7): 1185-91.

Horne-Thompson A. Grocke D. The effect of music therapy on anxiety in patients who are terminally ill. *Journal of Palliative Medicine*. 2008, **11**(4): 582-90.

Mannix KA. Blackburn IM. Garland A. Gracie J. Et al. Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliative Medicine.* 2006, **20**(6): 579-84.

Mitchell AJ. *Et al.* Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. *Lancet Oncology.* 2011; **12**(2):160-74.

Mitchell AJ. Meader N. Symonds P. Diagnostic validity of the Hospital Anxiety and Depression Scale (HADS) in cancer and palliative settings: a meta-analysis. *Journal of Affective Disorders.* **126**(3): 335-48, 2010

Moorey S. Greer S. Cognitive techniques II: applications of cognitive techniques to common problems. In, *Cognitive Behaviour Therapy for People with Cancer*. Oxford: Oxford University Press, 2002. pp121-6.

Roth, A.J., & Massie, M.JAnxiety and its management in advanced cancer. Current Opinion in Supportive and Palliative Care, . 2007; **1**(1): 50-56.

Sheard T. Maguire P. The effect of psychological interventions on anxiety and depression in cancer patients: results of two meta-analyses. *British Journal of Cancer.* 1999; **80**(11): 1770-80.

Vachon M. The emotional problems of the patient in palliative medicine. In, Hanks G, Cherney NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK. *The Oxford Textbook of Palliative Medicine, 4th ed.* Oxford University Press, 2009, pp 1410-36.

Wilkinson S. Aldridge J. Salmon I. Cain E. Wilson B. An evaluation of aromatherapy massage in palliative care. *Palliative Medicine.* 1999; **13**(5): 409-17.

Wilson KG. Chochinov HM. Skirko MG. Allard P. et al Depression and anxiety disorders in palliative cancer care. *Journal of Pain and Symptom Management.* 2007, **33**(2): 118-29.

Resource books

Effective Interaction with Patients, 2nd ed Faulkner A. New York : Churchill Livingstone, 1998.

e-lfh: e-Learning for Healthcare contains a range of online self-learning programmes, including several relating to end-of-life care (e-ecla). Registration is required but is free.

Introducing Palliative Care 5th ed. Twycross R., Wilcock A. www.palliativedrugs.com 2016

Talking to Cancer Patients and their relatives. Faulkner, A. Oxford: Oxford University Press, 1994.

A Guide to Symptom Relief in Palliative Care, 6th ed. Regnard C, Hockley J. Oxfgord: Radcliffe Medical Press, 2010

Oxford Textbook of Palliative Medicine 4th ed. Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK. eds. Oxford : Oxford University Press, 2010.