

# ANXIETY MANAGEMENT FOR PATIENTS WITH SYMPTOMS OF MI

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**ABSTRACT** Russell, V. (2006) Anxiety management for patients with symptoms of myocardial infarction. *Nursing Times*; 102: 47, 34–35.

This article reports on a systematic literature review focusing on improvements that could be made to nursing practice with regard to the psychological needs of patients with symptoms of MI. This is a summary of the paper; a full version can be accessed at [nursingtimes.net](http://nursingtimes.net).

A review was undertaken after I cared for a patient who had high levels of anxiety following an MI, as I felt his care could have been improved. An anxiety assessment tool was developed to help nurses assess anxiety in patients with symptoms of MI. The tool suggests appropriate interventions.

## AIM

This systematic review aimed to investigate the literature on anxiety in patients who are experiencing symptoms of MI and the provision of psychological care that can be made available to this group.

## METHOD

A literature search was undertaken to identify relevant articles. These were assessed for quality and bias and common themes were identified. A total of 5,268 articles were identified in the initial search but only 23 matched the inclusion criteria.

## RESULTS AND DISCUSSION

The review suggests that all patients with symptoms of MI experience some level of anxiety and that they are not always offered psychological interventions to alleviate this. Four subject categories emerged from the literature.

### Category 1. The nurse's role

Only one article included details on anxiety management. There is a lack of evidence of nurses' responsibilities in providing psychological care to patients with MI symptoms. There is also a lack of nursing knowledge of psychological reactions to MI and the evidence suggests psychological care is not universally provided.

### Category 2. Do patients need psychological care?

Three studies stated that the anxiety felt by MI patients can put further pressure on the heart. Kinzinger (1992) found that 80% of

participants reported discomfort, tension, fear and anxiety, while Bolwerk (1990) suggested that health professionals should regard all MI patients as anxious as they may be masking their anxiety. Strandmark (2004) warned that repressed feelings can transform into physical symptoms.

Cornock (1996) argued that emotional reactions to MI are linked to factors such as behavioural type, effect on Maslow's hierarchy of needs model, the health beliefs model and cognitive dissonance. For example, Maslow's hierarchy of needs model identifies levels of human need. Once one level of need is met, the individual moves to the next. The first level on the hierarchy is based on the need to feel safe – during an MI this need is not met.

The health beliefs model is concerned with beliefs that may influence patients' reactions to illness. The main example given is locus of control. People with an internal locus of control believe they can influence the features that affect life, while those with an external locus believe they are subject to fate and destiny and are not in control of their own lives. Those with an external locus are more likely to have reactions such as hopelessness and helplessness than those with an internal locus, who might use problem-solving coping strategies.

Cognitive dissonance involves the individual holding two inconsistent beliefs or opinions. This might be common in MI patients after resuscitation – they have a positive view of treatment – but it has failed because they needed resuscitation. In this case, they would experience dissonance and therefore a negative state.

Stewart et al (2000) recognised three coping strategies used by patients during their reaction to the situation: emotion-focused, problem-focused and relationship-focused. Patients using the emotion-focused strategy show signs of emotional suffering, while those using a problem-focused strategy may seek information. When the relationship-focused strategy is used, patients may show signs of wanting to

## BACKGROUND

- Most research on the nurse's role in caring for patients with the symptoms of MI focuses on practical skills and medical needs.
- Literature on MI patients' information needs suggests that nurses should adapt psychological interventions to suit the specific patient group.
- Patients' information needs are affected significantly by gender and cultural group (Clark et al, 1998; Fishel, 1998).
- Religion plays an important part in the way some patients cope with life-threatening illness.
- The most common emotional reactions to MI are anxiety, fear and anger, along with feelings of hopelessness, helplessness and worthlessness (Cornock, 1996).
- Health professionals should regard all patients with symptoms of MI as anxious because they may be masking their anxiety (Bolwerk, 1990).



### IMPLICATIONS FOR PRACTICE

- This review has highlighted the lack of psychological care being provided to patients with symptoms of MI and suggests these patients need psychological care due to the damaging effect of anxiety on the already compromised heart.
- The patients' main psychological requirement appears to be a need for information from health professionals, while a number of interventions may help to reduce severe anxiety.
- Integrating the assessment tool within the observations charts used to record vital signs would remind nurses that these patients need psychological care and their anxiety levels should be assessed regularly.
- Nurses should also ask patients whether any spiritual care would help reduce their anxiety and improve their ability to cope – in such cases it may be necessary to involve others, such as a hospital chaplain or another appropriate religious practitioner.
- This study suggests that one type of benzodiazepine should be prescribed on the 'as required' section of the drug chart, for all patients presenting with symptoms of MI, so they can receive it immediately if they score 4 on the anxiety scale.

### REFERENCES

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communicate with healthcare professionals. This latter strategy has the greatest potential to be effective.

#### Category 3. What psychological needs were highlighted?

Cronin and Harrison's (1988) study suggested that patients want their basic medical needs to be satisfied before their more complex psychological needs. However, it also suggested that patients' complex needs are not being met after their basic ones have been attended to.

The need for information was a common theme. Zininger (1992) suggested that anxiety is often compounded by lack of information, while Moller et al (2004) found that MI patients' knowledge of their illness is poor. In their study, 48% of participants could not explain what an MI was.

Clark et al (1998) identified that cultural factors can heavily influence patients' perspectives of health and illness, while Fishel (1998) stated that studies have revealed substantial differences in the symptoms of anxiety presented in different cultural groups. Both studies highlighted the lack of research into cultural and minority groups within this area of healthcare.

Albaugh (2003) highlighted the importance of spirituality to religious patients in terms of coping with life-threatening illness, which suggests patients' spiritual needs must be attended to.

#### Category 4. What psychological care?

Fishel (1998) used a tool to assess levels of anxiety against suggested interventions such as medication (benzodiazepines), empowerment, music therapy, breathing exercises and touch therapy. While it has the potential to improve care, the tool is relatively complex and time-consuming, and is therefore unlikely to be practical for use in A&E and general wards where most patients with MI are cared for.

#### OUTCOME

The findings led to the design of an anxiety assessment and intervention tool, the aim of which is to reduce patients' anxiety. It can be used on all patients with MI symptoms and involves asking patients to rate their anxiety on a scale of 1–4. Interventions are recommended for each level.

The tool recommends all patients be given information on equipment, procedures, diagnosis and prognosis. Those on level 2 of the scale should receive sensory therapy such as noise reduction, touch therapy and environmental awareness during interactions, such as pulling the curtain or sitting close to the patient. Breathing exercises are used in patients on levels 3 and 4 of the scale to control their breathing patterns. Pharmaceutical interventions (benzodiazepines) are only recommended for patients on level 4, to prevent further damage to the already compromised heart. ■

● For the full version of this paper including results, full methodology, discussion and recommendations, log on to [nursingtimes.net](http://nursingtimes.net), click **NT Clinical and Archive** and then **Clinical Extra**