Patients experiencing cancer also can experience anxiety. Moderate to severe levels of anxiety can interfere with patients’ ability to concentrate and comprehend new information. The condition is particularly troublesome when trying to present educational material related to recommended treatment interventions. Patients’ understanding of the material is critical to ensure informed consent. Informed consent can be compromised if patients are unable to understand the information being provided. Nurses must be cognizant of the impact that anxiety has on patient education and assess patients prior to initiating patient teaching. By managing anxiety before beginning education, nurses can provide an environment more conducive to learning.

Before the Teaching Begins:
Managing Patient Anxiety Prior to Providing Education

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The United States’ current medical system encourages patients to be active participants in their plans of care. Unfortunately, after a cancer diagnosis, decisions must be made quickly, which can be overwhelming and result in patients experiencing psychosocial distress, including anxiety (Gobel, 1996).

Anxiety is defined as a response to a perceived threat and is associated with a vague, unpleasant uneasiness (Clark, 1992). Approximately 28% of the general population will meet the criteria for anxiety at one point in their lifetime (Kaplan & Sadock, 1998). The number rises to 44% among those diagnosed with cancer, illustrating the prevalence of the problem (National Cancer Institute, 2006). Anxiety can occur with or without associated depression. Not all anxieties are severe enough to be debilitating. Pathologic anxiety disorders include phobias, panic attacks, and post-traumatic stress disorder (Kaplan & Sadock).

Mild anxiety can be useful during a crisis by making individuals more alert to their environment. As attention and awareness are stimulated, concentration is enhanced. Unfortunately, once anxiety escalates to moderate levels, concentration becomes compromised. Severe or panic anxiety experienced by patients can be detrimental to learning and should be managed before education begins (Smith-Alnimer, 1996).

Significant levels of anxiety can threaten patients’ quality of life and interfere with their ability to concentrate and understand information, ultimately influencing informed consent (Bush, 1998). Because people can experience anxiety at any point during the cancer trajectory, clinicians always should be aware of patients’ anxiety levels, particularly as new information is presented (Clark, 1992).

Nurses may be unaware of the impact that anxiety has on patients’ ability to concentrate and learn. This article will discuss the importance of assessing and managing anxiety before initiating patient education related to a cancer diagnosis or treatment. Although patients may experience several types of psychological distress with cancer (e.g., depression, denial) and nurses are capable of providing many interventions that facilitate learning, this article will focus on patients with significant anxiety prior to patient education and its impact on comprehension and learning.

Types of Anxiety

Several types of anxiety have been described, including reactive, preexisting, and anxiety related to drugs or medical conditions (Sivesind & Rohaly-Davis, 1998). Reactive anxiety, also known as situational or stress anxiety, is an acute form of anxiety that occurs in response to a stressor or traumatic event. Needle phobias or claustrophobia associated with magnetic

At a Glance

✦ Patients can experience anxiety at any point during their cancer experience.
✦ Moderate to severe levels of anxiety can interfere with a person’s ability to comprehend information.
✦ Managing anxiety prior to providing patient education can improve patient comprehension and informed consent.
resonance imaging are examples of acute, reactive anxiety. Those anxieties occur in response to a particular situation and are relieved once the stressor is removed. Preexisting, or trait, anxiety refers to a prior history or tendency to become anxious. Finally, several drugs or medical conditions can mimic anxiety-like symptoms (see Figure 1). Identifying the source of anxiety will determine the best intervention for relief.

Assessing Anxiety

Patients should be assessed for anxiety and their willingness to learn before proceeding with education. Figure 2 provides a pathway for the assessment of anxiety and provision of patient education. Although many patients want as much information as possible, others may not (Thomas, Thornton, & Mackay, 1999). Nurses must understand the educational needs of their patients, including the type and amount of information desired. If patients refuse education, nurses have an obligation to advise them that receiving information related to their disease and treatment is critical in ensuring that an informed decision is made. A compromise would be to allow patients to control how much information they receive. If patients still choose not to receive even vital information, the physician should be notified.

Patients who agree to receive information should be assessed for psychosocial interference, including anxiety. Information can be gathered using formal documentation tools or informal conversations with patients (Spielberger, Gorsuch, & Lushene, 1970; Worden & Weisman, 1984). Examples of formal anxiety assessment tools are provided in Figure 3. A thorough assessment of anxiety should include collection of verbal and nonverbal cues, evaluation of current stressors, a review of patients’ social support system, a history of previous coping patterns, and assessment of their expectations or prior experiences with cancer and its treatment (Bush, 1998). For more detailed information about data collection instruments, see Frank-Stromborg and Olsen (2004).

Several obstacles can interfere with assessment of anxiety, including patients’ reluctance to reveal their anxiety because of fears of stigmatization or weakness (Frith, 1991). Others may suppose that anxiety is beyond oncology clinicians’ expertise and choose not to confide in them, believing that only psychi-

trists are trained to deal with psychological issues. Therefore, nurses must pay close attention to behavioral cues in addition to verbal indicators when assessing anxiety. Behavioral or nonverbal indicators of anxiety include restlessness, wringing of hands, preoccupation, or staring into space (Bush, 1998). Patients experiencing anxiety also may complain of upset stomach, tachycardia, diarrhea, or palpitations (Kaplan & Sadock, 1998).

The presence of competing stressors can be distracting to patients, interfering with their ability to concentrate on new information. Stressors can be physical, financial, or social (Sivesind & Rohaly-Davis, 1998). Pain or other uncontrolled symptoms are examples of physical stressors that can prevent patients from concentrating adequately. Struggling with lost wages or tremendous medical expenses can leave patients feeling overwhelmed financially and unable to concentrate on the information at hand. Patients need positive social support systems to process anxiety and integrate the illness into their reality. Patients who lack such support may not be able to talk about their crisis, which is critical to relieve moderate to severe anxiety (Ingebrigtsen & Smith, 1997). Communication with appropriate team members can help patients to reduce their current stressors by allowing them to feel supported by compassionate professionals who understand their concerns.

A review of prior coping mechanisms can reveal individuals’ tendencies toward maladaptive or dangerous trends. For example, patients who have admitted to a history of relying on drugs or alcohol to cope with a crisis might be predisposed to return to similar coping mechanisms. By anticipating maladaptive coping mechanisms, clinicians can intervene proactively, making appropriate referrals to mental health professionals.

Reviewing prior experiences with cancer, whether personal or through the observations of others, can reveal patients’ expectations about their cancer treatment and outcomes. Such expectations can be influenced by life experiences or incorrect information. Beginning the educational process by correcting misconceptions can relieve anxiety enough to allow patients to focus on their educational needs. For example, many people fear that their cancer is contagious and worry about the safety of their loved ones. Correcting this misconception can alleviate their concerns, improving patients’ ability to concentrate on a plan to promote their own well-being.

Managing Patient Anxiety

If evidence of psychological interference exists, such as anxiety, steps should be taken to reduce it before continuing with the educational process. Anxiety that interferes with the ability to learn or quality of life may require nonpharmacologic or pharmacologic intervention.

Nonpharmacologic interventions can be divided into those requiring little instruction to learn and skills that must be practiced. For example, journaling, participation in support groups, and psychoeducation are interventions that require little instruction and have the potential to relieve anxiety quickly. On the other hand, cognitive and behavioral psychotherapy and relaxation techniques (e.g., progressive relaxation, guided imagery, meditation, yoga) require varying degrees of instruction and practice before patients can participate

![Figure 1: Medical Conditions and Medications That Mimic Anxiety-Like Symptoms](image-url)
successes. Such interventions may not be suitable for patients experiencing an acute crisis. Those techniques are best learned when patients are not experiencing acute anxiety; the goal in learning them is to provide helpful coping mechanisms for future needs.

Psychoeducation is one example of an intervention that lessens anxiety and requires little instruction. It works on the premise that fear and anxiety result from a lack of understanding. Devine and Westlake (1995) described psychoeducational methods as offering educational and psychosocial interventions. By providing information, patients regain a sense of control over their cancer and treatment. Psychoeducation incorporates health education, support groups, the venting of emotions, and behavioral techniques to deal with the illness (Barsevick, Sweeney, Haney, & Chung, 2002; Devine & Westlake; Lethborg & Kissane, 2003).

Several studies have demonstrated the effectiveness of psychoeducation in patients with cancer. Devine and Westlake (1995) completed a meta-analysis of the effects of psychoeducation and found that it did reduce the degree of anxiety experienced by adult patients with cancer. McQuellon and colleagues (1998) developed an orientation program to provide education to newly diagnosed patients with cancer and found that individuals who participated in the program demonstrated lower levels of anxiety than did the control group. Katz, Irish, and Devins (2003) created an educational brochure for patients diagnosed with oral cancer for the purpose of educating and facilitating effective coping. Findings indicated lower levels of anxiety and a trend toward improved well-being.

Fedorchuk, Mendiondo, and Matar (2003) indicated that although patients can experience anxiety at any time, debilitating anxiety is most prevalent with a new diagnosis. Newly diagnosed patients, in particular, may not have had an opportunity to integrate cancer into their reality. They often describe themselves as feeling numb or blindsided. Patients need to develop relationships with oncology healthcare professionals who can

Figure 2. Pathway for the Assessment of Anxiety and Provision of Patient Education

The patient is agreeable to receiving educational materials.

Assess anxiety. Assess (a) behavioral cues: verbal and nonverbal, (b) current stressors: physical, financial, and social, (c) support systems, (d) prior coping mechanisms, and (e) expectations or prior experiences with cancer. Does the patient appear to have anxiety that could interfere with education?

YES

Attempt to discuss anxiety with the patient. Formulate a plan or make introductions to other team members able to help with important issues. Identify and clear misconceptions about the cancer therapy. Is the patient better prepared to concentrate now?

NO

Consult with team members about the need for mental health involvement and other strategies to help the patient manage anxiety.

YES

Explain the need to cover critical information to ensure that the patient is making an informed decision when receiving treatment. Be sure to explain that eventually all information must be discussed but that you will agree to go slow. Is the patient willing to proceed with education?

NO

Notify the physician of the patient’s unwillingness and inability to ensure informed consent.

YES

Proceed with patient education.

What does the patient understand so far, and what is most important to learn about now?

Assess readiness to learn, amount of information desired, prioritization preferred, and method of learning.

Prioritize information. Only provide as much information as the patient can handle at one time.

Provide supportive materials to take home (e.g., written, video, audio).

Encourage the patient to bring a list of questions that may develop to the next appointment.

Reinforce education and provide new information with subsequent visits until the patient has a thorough understanding of the treatment protocols.

Figure 2. Pathway for the Assessment of Anxiety and Provision of Patient Education

NO
offer comfort and compassionate support. They may need to be introduced to appropriate team members to reduce their anxiety before education can be initiated. Occasionally, prescribing antianxiety medications, or anxiolytics, might be necessary.

Anxiolytics, including benzodiazepines and nonbenzodiazepines, are the most common pharmacologic interventions. Benzodiazepines are useful because of their rapid onset and short half-life. Adverse effects include sedation, confusion among older adults, and addiction with prolonged use. Benzodiazepines include lorazepam, oxazepam, diazepam, alprazolam, and clorazepate. Buspirone is a nonbenzodiazepine that does not have the adverse effects or addictive qualities of benzodiazepines. Unfortunately, buspirone is not as effective as benzodiazepines against anxiety and requires two to three weeks to achieve a therapeutic blood level, thus delaying efficacy (Bush, 1998; Fuller & Sajatovic, 2004).

Providing Education

Once they feel comfortable that any debilitating anxiety or other psychological interferences have been controlled, nurses may proceed with patient information. The irony is that fear stemming from the illness can interfere with patients’ abilities to comprehend information, yet education is often a good intervention to relieve anxiety. The trick is to carefully select the most appropriate information to convey to patients.

Self-Regulation Theory (Johnson, Fieler, Jones, Wlasowicz, & Mitchell, 1997) is a nursing theory that helps nurses choose the most relevant information for patient education that will assist with coping with illness. Each individual is a unique sum of their experiences and expectations; therefore, patient education should be tailored to individuals’ needs. The theory explains that patients’ response to physical illness can be functional (objective) or emotional (subjective). Emotional responses include anger and anxiety. By focusing on the emotional experience, patients can have feelings of vulnerability and distress. As a result, energies will be directed toward coping with these vulnerabilities rather than participating in their care. Self-Regulation Theory helps nurses redirect attention from the emotional response to the functional or objective response, allowing patients to become more involved in their care and improve coping. Information shared with patients should be derived from four concrete variables describing the experience: (a) a description of the physical sensations patients might experience, (b) the temporal characteristics of the event, (c) what the environment will be like during the event, and (d) concrete descriptions of what symptoms may be experienced because of the event (Johnson et al.).

When planning to provide education to patients, nurses must determine what patients understand about their diagnosis and treatment thus far. Preliminary assessment of patients’ readiness for learning should include the amount of information they desire, a prioritization of what is most important for them to learn first, their preferred method of learning (e.g., reading, interactive learning, listening), and factors that might impede learning (e.g., anxiety, pain, fatigue, communication impairments, level of education) (Bush, 1998; Gobel, 1996). Many patients will benefit from receiving more than one instructional method, such as a combination of written literature, videotapes, audiotapes, and access to the Internet (Thomas et al., 1999).

The need for information should be prioritized for urgency. If adjuvant treatment is postponed because of postoperative healing, time may be better spent initially by helping patients adjust to the reality of their diagnosis. Patients with advanced or aggressive disease may not have much time to adjust to their diagnosis before treatment begins. Patients in such a position may find that absorbing the information included in their educational plan is difficult.

Some individuals will thrive on knowledge related to the cancer and treatment, whereas others prefer a passive approach (Thomas et al., 1999). The goal is to inform without overwhelming. Nurses may need to break educational material into several discussions. Select the most critical information needed to ensure informed consent, and present that first. For example, potential toxicities related to medications must be reviewed before treatments can begin, but general postchemotherapy instructions can be postponed safely until the end of the first treatment.

Written information can serve as a quick reference for patients at home (Fisch et al., 1998; Nair, Hickok, Roscoe, & Morrow, 2000). Because of the overwhelming volume of information patients must understand, reinforcement of educational material during subsequent visits is important. Encourage patients and their families to write questions down as they arise between clinical visits. Relying on their memories to recall questions spontaneously when they return to the clinic can be disappointing because resurfacing anxiety and other distractions can interfere.

Conclusion

Patients can experience anxiety at any point during their cancer experience. Moderate to severe anxiety can interfere with patients’ ability to concentrate and comprehend new information. Providing education to patients with anxiety can lead to limited understanding. Informed consent can be compromised if patients are unable to understand information being
provided. Nurses should be cognizant of the impact that anxiety has on patient education and assess patients prior to initiating patient teaching. By managing anxiety before initiating education, nurses can provide the environment and material most conducive to learning. Through the patience and perseverance of nurses, patients can have a thorough understanding of their disease and its treatment as well as the role they play in the successful management of their cancer experience.

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