International Journal of Computational and Experimental Science and ENgineering (IJCESEN)

Vol. 10-No.4 (2024) pp. 3343-3349
http://www.ijcesen.com

ISSN: 2149-9144

Research Article

Nursing Strategies for Managing Anxiety and Stress in Patients Admitted to Emergency Departments

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Article Info:

DOI: 10.22399/ijcesen.4613
Received : 01 May 2024
Accepted : 30 May 2024

Keywords

Nursing Strategies,
Anxiety Management,
Stress Reduction,
Emergency Department Care,
Patient Communication,
Rapport Building

Abstract:

Nurses play a crucial role in alleviating anxiety and stress among patients in emergency departments (EDs), where the environment is often chaotic and overwhelming. One effective strategy is to establish rapport and trust with patients through active listening and empathetic communication. By acknowledging the patient's fears and concerns, nurses can create a supportive atmosphere that helps reduce anxiety. Additionally, providing clear information about procedures, wait times, and what to expect can empower patients, reducing uncertainty and fear. Incorporating calming techniques such as deep breathing exercises and mindfulness can also help patients regain a sense of control and reduce their immediate stress levels. Another essential approach involves the use of environmental modifications to create a more soothing space. This can include minimizing noise, providing privacy whenever possible, and ensuring that patients have access to comforting items, such as blankets or personal belongings. Collaborating with interdisciplinary teams to assess and address the psychological needs of patients can further enhance care. For instance, mental health professionals can be involved for patients experiencing severe anxiety or panic attacks. Ultimately, a combination of compassionate care, effective communication, and environmental support is vital for nurses in the ED to manage stress and anxiety, promoting a more positive patient experience.

1. Introduction

The Emergency Department (ED) represents a unique and critical nexus within the healthcare system, characterized by its inherent unpredictability, high acuity, rapid pace, and often overwhelming sensory environment. For patients, arrival at the ED is seldom a planned event; it is frequently a culmination of a sudden, frightening, and potentially life-altering health crisis. This context creates a perfect storm for the experience of intense psychological distress, manifesting primarily as acute anxiety and stress. Patient anxiety in the ED is not merely a peripheral concern or an expected byproduct of illness; it is a significant clinical phenomenon that can profoundly influence physiological stability, pain perception, decision-making capacity, diagnostic accuracy, and overall healthcare outcomes [1, 2]. The anxiety experienced can range from a mild, situational nervousness to severe, debilitating panic attacks or exacerbations of pre-existing anxiety disorders, all of which are amplified by the unfamiliar, chaotic, and procedurally invasive nature of the emergency care environment.

Stress, in this context, refers to the physiological and psychological response to the perceived threat posed by the medical emergency and the ED milieu itself. This triggers the hypothalamic-pituitary-adrenal (HPA) axis, releasing cortisol and catecholamines, leading to tachycardia, hypertension, hyperventilation, and increased muscular tension [3]. These somatic symptoms can often mimic or worsen the presentation of the primary medical condition, such as chest pain or dyspnea, creating a complex diagnostic and management challenge. Therefore, the effective management of anxiety and stress is not a luxury of care but an integral, non-negotiable component of quality emergency nursing practice. It aligns with a holistic, patient-centered model that acknowledges the indivisibility of mind and body [4].

Emergency nurses, positioned at the forefront of patient interaction, bear the pivotal responsibility of recognizing, assessing, and intervening to mitigate this distress. Their role extends beyond technical proficiency in clinical tasks to encompass the nuanced art of therapeutic communication, environmental modulation, and the application of evidence-based psychological strategies [5].

2. The Etiology and Impact of Anxiety and Stress in the ED Setting

Understanding the specific sources of patient anxiety is the first step toward its effective management. The genesis of this distress is multifactorial, stemming from interactions between patient-specific factors and the intimidating ED ecosystem.

One primary source is **Fear of the Unknown and Loss of Control**. Patients suddenly find themselves in a vulnerable position, stripped of their autonomy, personal clothing, and familiar routines. They often possess limited information about their diagnosis, the meaning of various tests, the timeline for care, or their eventual prognosis [4]. This informational vacuum is fertile ground for catastrophic thinking. The lack of control over what happens to their body, coupled with uncertain waiting periods, significantly elevates anxiety levels. Furthermore, the **Perceived Threat to Life and Well-being** is a potent trigger. The very reason for ED admission—be it chest pain, severe trauma, acute neurological symptoms, or intense pain—carries an implicit threat. Patients grapple with fears of mortality,

permanent disability, chronic illness, or drastic changes to their life trajectory, which naturally precipitates acute stress responses [5].

The **ED Environment itself** is a significant independent stressor. The constant activity, bright lighting, alarming sounds of monitors and sirens, frequent overhead pages, and the sight of other distressed patients contribute to sensory overload [6]. Privacy is often minimal, with conversations and examinations conducted in curtained bays, amplifying feelings of exposure and vulnerability. Additionally, **Pain and Discomfort**, which are common presenting problems, are intrinsically linked to anxiety. The two share a bidirectional relationship; anxiety lowers the pain threshold and intensifies the perception of pain, while unrelieved pain is a direct cause of escalating anxiety and agitation [7].

Finally, underlying **Patient-Specific Factors** play a crucial modulating role. Individuals with a history of anxiety disorders, post-traumatic stress disorder (PTSD), prior traumatic healthcare experiences, or cognitive impairments (e.g., dementia) are at substantially higher risk for severe distress in the ED [8]. Socioeconomic factors, language barriers, and health literacy levels can also exacerbate anxiety by hindering effective communication and understanding.

The impact of unmanaged anxiety is far-reaching. Physiologically, it can cause tachycardia, hypertension, tachypnea, and increased oxygen consumption, which can be deleterious for patients with cardiac or respiratory compromise [9]. It can also impair immune function and wound healing. Behaviorally, anxiety may manifest as agitation, uncooperativeness, or repeated calls for attention, which can strain nurse-patient relationships and divert resources. Cognitively, it can impair a patient's ability to process information, provide an accurate history, or give informed consent, thereby compromising the safety and efficacy of care [10].

3. Assessment and Recognition:

Effective intervention is predicated on accurate and timely assessment. In the fast-paced ED, formal psychiatric evaluations are often impractical, necessitating that nurses employ efficient, focused assessment skills to identify anxiety and stress.

Verbal and Non-Verbal Cues are the primary immediate indicators. Nurses must be astute observers of a patient's affect, body language, and speech patterns. Signs of anxiety include restlessness, pacing, clenched fists, jittery movements, trembling, fidgeting, and facial expressions of fear or wide-eyed scanning of the environment [11]. Verbally, patients may express worry directly ("I'm so scared," "Am I going to die?"), or their anxiety may be communicated through rapid, pressured speech, repeated questioning, or angry outbursts which may mask underlying fear. **Physiological Parameters** provide objective correlative data. Nurses should monitor vital signs for elevations in heart rate, blood pressure, and respiratory rate that are disproportionate to the primary medical condition. Pallor, diaphoresis, and complaints of dizziness or nausea are also common somatic manifestations of anxiety [12].

For a more structured approach, several **Brief Screening Tools** have been validated for use in acute care settings. The **Visual Analogue Scale for Anxiety (VAS-A)**, where patients mark their anxiety level on a 100mm line from "no anxiety" to "worst anxiety imaginable," is extremely quick and simple to administer [13]. The **State-Trait Anxiety Inventory (STAI)** short form can distinguish between temporary "state" anxiety and a general predisposition to anxiety ("trait"), providing valuable context [14]. The **Numeric Rating Scale (NRS) for anxiety**, akin to pain scales (0-10), is also easily integrated into routine nursing assessments. Incorporating a simple anxiety score alongside the standard pain score during triage and reassessment can normalize the discussion of psychological distress and facilitate monitoring of intervention efficacy [15].

Crucially, assessment is not a one-time event but a continuous process. Anxiety levels can fluctuate dramatically based on test results, waiting times, procedural preparations, and changes in clinical condition. Continuous re-assessment allows for the dynamic adjustment of nursing strategies.

4. Individual-Level Nursing Interventions:

The core of anxiety management lies in the one-to-one therapeutic relationship between the nurse and the patient. Through deliberate communication and presence, nurses can create islands of calm within the chaos.

Therapeutic Communication and Active Listening are the most powerful non-pharmacological tools available. This begins with a calm, confident, and empathetic demeanor. Introducing oneself clearly, making eye contact (where culturally appropriate), and using the patient's name conveys respect and personalization. Active listening involves giving the patient full attention, acknowledging their feelings ("It sounds like this is really frightening for you"), and avoiding premature reassurance or minimization of their concerns [16]. Instead of saying "Don't worry, everything will be fine," a more therapeutic

response is, "I hear how worried you are about these test results. It's understandable. Let me explain what we know right now and what the next steps are." This validates their emotion and builds trust.

Provision of Information and Enhanced Communication directly targets the fear of the unknown. Nurses should provide clear, concise, and honest information about procedures, waiting times, and plan of care. Using simple, non-medical language is essential. For example, before starting an intravenous line, explaining "You'll feel a sharp pinch for a few seconds, then it will be over" prepares the patient and reduces surprise-induced anxiety [17]. Encouraging questions and checking for understanding ("I've given you a lot of information; what questions do you have for me?") empowers the patient. Regular updates, even if there is no new information ("The doctor is still reviewing your scans; I will check back with you in 20 minutes"), can significantly reduce anxiety stemming from abandonment fears [18].

Psychological First Aid and Calming Techniques can be taught simply and implemented at the bedside. Guided breathing exercises are highly effective; instructing a patient to "breathe in slowly through your nose for a count of four, hold for two, and breathe out slowly through your mouth for a count of six" can quickly reduce sympathetic nervous system arousal [19]. For some patients, simple distraction techniques—such as engaging in light conversation about neutral topics, offering a magazine if appropriate, or guiding them through a mental imagery exercise (e.g., imagining a peaceful place)—can break the cycle of anxious thoughts. Acknowledging and normalizing their feelings ("Many people feel anxious in situations like this; it's a normal reaction") can also reduce secondary distress about feeling anxious.

5. Environmental Modifications and Comfort Measures

While the overall ED environment is challenging, nurses can implement micro-level modifications to the patient's immediate space to reduce sensory assault and promote a sense of safety.

Minimizing Sensory Overload is a key strategy. This can involve dimming the lights in the patient's bay if possible and clinically safe, closing the room curtain fully to create a visual barrier, and reducing unnecessary noise by closing doors or speaking in softer tones [20]. If a patient is particularly sensitive to sound, offering earplugs or noise-canceling headphones can be a simple yet profound intervention. **Optimizing Comfort** through basic nursing care has a strong anxiolytic effect. Ensuring patients are warm with blankets, assisting them into a position of comfort, managing pain promptly and effectively, and addressing basic needs like thirst (if permitted) or a dry gown all communicate care and reduce physical contributors to distress [21].

Promoting Privacy and Dignity is non-negotiable. Ensuring curtains are closed during examinations and conversations, exposing only the necessary body parts for procedures, and speaking discreetly about sensitive information protect the patient's dignity and mitigate feelings of vulnerability and exposure that fuel anxiety [22]. Furthermore, when feasible and safe, **Facilitating Familiar Social Support** is invaluable. Allowing a trusted family member or friend to remain with the patient can provide immense comfort, assist with communication, and help orient the patient. The supportive presence of a loved one is one of the most potent buffers against acute stress.

6. Systemic and Collaborative Strategies

Individual nursing efforts must be supported by systemic structures and collaborative practices to be sustainable and effective across the entire ED patient population.

Interprofessional Collaboration is essential. Nurses should actively communicate their assessments of patient anxiety to physicians, physician assistants, and nurse practitioners. This ensures that anxiety is considered in the differential diagnosis (e.g., ruling out organic causes of agitation) and in the treatment plan. Collaborative discussions can lead to timely prescriptions for anxiolytic medications when non-pharmacological measures are insufficient. Similarly, early consultation with **Social Workers, Chaplains, or Psychiatric Liaison Nurses** can provide specialized support for patients in extreme distress, those with pre-existing mental health conditions, or those facing devastating diagnoses [23]. These professionals are skilled in crisis intervention and can offer resources for longer-term support.

Protocols and Triage Integration can standardize best practices. Developing and implementing a clinical protocol for the identification and initial management of anxiety ensures that all patients are screened and that nurses have a clear pathway for intervention [24]. Integrating a brief anxiety screening into the triage process, similar to pain assessment, signals its clinical importance. Furthermore, **Staff Education and Self-Care** are critical but often overlooked components. Hospitals must invest in training ED staff in de-escalation techniques, communication skills, and basic psychological support strategies. Equally important is acknowledging the high-stress nature of ED work

and providing resources for staff resilience, such as debriefing sessions after critical incidents. A less stressed, more supported nursing team is better equipped to provide calm, compassionate care [25].

7. Pharmacological Interventions and the Nurse's Role

While non-pharmacological strategies are first-line, pharmacological intervention is a necessary and appropriate adjunct for moderate to severe anxiety that impairs care or causes extreme suffering.

Common Anxiolytic Medications used in the ED include benzodiazepines (e.g., lorazepam, midazolam) for rapid short-term relief, and sometimes antihistamines like hydroxyzine. It is crucial to understand that medication is not a standalone solution but should be **Integrated with Non-Pharmacological Care**. The nurse's role in pharmacological management is multifaceted. It involves accurate assessment to inform the need for medication, safe administration with continued monitoring of vital signs and level of consciousness, and vigilant observation for side effects such as respiratory depression or paradoxical reactions [26]. Importantly, administering medication should not end the nurse's therapeutic engagement. Continuing to use calming communication and environmental strategies while the medication takes effect represents holistic care.

8. Special Considerations and Vulnerable Populations

A one-size-fits-all approach is ineffective. Tailoring strategies to specific populations is a mark of expert nursing care.

Pediatric Patients experience and express anxiety differently. Strategies include using age-appropriate language, providing comfort items from home (a stuffed toy), utilizing child life specialists for procedural preparation and distraction, and always involving parents in care and comfort measures to the greatest extent possible [27]. **Geriatric Patients** may have sensory impairments, cognitive decline, or multiple comorbidities. Interventions require speaking clearly and facing the patient, ensuring hearing aids and glasses are available, avoiding infantilizing language, and being aware that confusion or agitation may be a manifestation of anxiety or an underlying condition like delirium [28].**Patients with Cognitive Impairments or Dementia** present a distinct challenge. They may be unable to understand explanations or communicate their fear. Management focuses on creating a calm environment, using simple and reassuring touch, maintaining a consistent caregiver when possible, and avoiding physical or chemical restraints unless absolutely necessary for safety [29]. For **Patients with Pre-existing Mental Health Conditions**, such as PTSD or severe anxiety disorders, the ED environment can be particularly triggering. Collaboration with psychiatric services is key. Nurses should ask about known triggers, respect personal space, and be aware that certain behaviors are expressions of trauma-related anxiety [30].

Patients from Diverse Cultural Backgrounds require cultural humility. Nurses must be aware of how anxiety and distress are expressed differently across cultures (somatically vs. emotionally) and be respectful of health beliefs and practices. Utilizing professional interpretation services, rather than family members, is critical for sensitive communication and obtaining informed consent [31].

9. Evaluation of Interventions and Outcomes

The efficacy of nursing strategies must be evaluated to ensure quality and guide practice improvements. Evaluation can occur on multiple levels.

At the **Individual Patient Level**, re-assessment using the same brief scale (e.g., NRS-A) administered pre- and post-intervention provides direct feedback on effectiveness. Observing changes in physiological parameters, body language, and cooperation also offers clear indicators. On a **Unit or Departmental Level**, metrics such as rates of patient satisfaction specifically related to communication and emotional support, the frequency of use of chemical or physical restraints (which should decrease with better anxiety management), and staff-reported incidents of patient agitation can serve as valuable outcome measures [32]. Qualitative feedback from patients and families through surveys or interviews can provide rich, nuanced data on the experience of care.Ultimately, the evaluation should feed into a **Continuous Quality Improvement (CQI)** cycle. Data on outcomes should be reviewed by ED leadership and clinical staff to identify successful strategies, areas for improvement, and needs for further staff education or protocol development. This ensures that the management of patient anxiety remains a dynamic and evolving priority [33].

10. Conclusion

The management of anxiety and stress in patients admitted to the Emergency Department is a complex, indispensable, and fundamentally human aspect of emergency nursing. It transcends

technical skill, residing instead in the deliberate, compassionate, and evidence-based application of holistic care principles. As this article has detailed, effective management requires a multi-layered approach: from the foundational skill of astute assessment and the powerful tool of therapeutic communication, through targeted environmental modifications, to systemic supports and judicious pharmacological collaboration.Emergency nurses operate at the intersection of crisis and care. By recognizing that the patient in Bed 4 is not merely a case of "abdominal pain" but a person experiencing fear, uncertainty, and loss of control, the nurse transforms the care encounter. The strategies outlined—from a simple act of providing information to the complex orchestration of interdisciplinary support—serve to restore a measure of dignity, control, and calm to the patient in their most vulnerable moment. This is not ancillary work; it is central to the mission of healing. It improves physiological outcomes, enhances diagnostic accuracy, increases patient satisfaction and compliance, and humanizes the high-stakes environment of emergency care. Therefore, investing in the knowledge, skills, and systemic structures that empower nurses to effectively address anxiety is an investment in the very core of safe, effective, and compassionate emergency medicine. The challenge is significant, but the imperative is clear: to treat not only the disease manifesting in the body but also the profound distress residing in the mind of the emergency patient.

Author Statements:

- **Ethical approval:** The conducted research is not related to either human or animal use.
- **Conflict of interest:** The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper
- **Acknowledgement:** The authors declare that they have nobody or no-company to acknowledge.
- **Author contributions:** The authors declare that they have equal right on this paper.
- **Funding information:** The authors declare that there is no funding to be acknowledged.
- **Data availability statement:** The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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