

Anxiety: Adolescent Patients - CE

ALERT

Anxiety can lead to challenging and dangerous behaviors (e.g., throwing objects, destroying property, self-injury, assault, suicide). Unresolved anxiety, as well as ineffective coping with anxiety, can lead to depression. Regularly occurring anxiety in an adolescent patient may be a sign of depression or another underlying mental health issue.

OVERVIEW

Anxiety disorders in children and adolescents are often precursors to psychiatric disorders in later adolescence and adulthood. These disorders may include additional subsequent anxiety disorders, major depression, substance abuse, self-injurious behaviors, and suicide attempts.⁵

Anxiety is different than fear. The two conditions share some similarities but have many differences. Fear is typically a healthy, natural emotional reaction to an impending threat; it has a direct cause and promotes safety. Anxiety is the expectation of an imagined or potential threat; it tends to be vague and unfocused. Fear is commonly combined with an acute arousal of the autonomic system needed for fight or flight and thoughts and behaviors associated with immediate danger and escape. Anxiety can affect emotions, thought processes, bodily sensations, and behaviors. With anxiety, vigilance, preparation for future threats, caution, and avoidant behaviors are more common.¹

An adolescent patient's memories, experiences, and social situations play intricate roles in the experience of stress and the development of anxiety. The adolescent may experience vague anxiety stemming from past pain and suffering or fear. Because these experiences are unique to each person, understanding or relating to the adolescent's stress and anxiety may be difficult.

Anxiety is characterized by:^{1,2}

- Physical complaints (e.g., chest tightness, dizziness, nausea, headache)
- Cognitive symptoms (e.g., impaired judgment, confusion, inability to make decisions)
- Behavioral issues (e.g., avoidance, impulsiveness, isolation, arguing, refusal to cooperate, attempts to control others)
- Emotional symptoms (e.g., worry, irritability, sense of dread, a feeling of being overwhelmed, frustration)

An anxiety disorder often occurs concomitantly with physical, emotional, or mental illnesses or substance abuse. These other issues can also hide or aggravate anxiety symptoms. Assessment for an anxiety disorder must be part of a comprehensive examination that includes a detailed history, physical assessment, a review of symptoms, and assessments of associated functional impairments, current psychosocial issues, and other contributing factors.⁷

Adolescent patients may experience anxiety differently than adult patients. Adolescents typically have more anxiety regarding social relationships and may avoid social activities, such as talking in groups or school.^{1,2} Adolescents with an anxiety disorder are more likely to demonstrate irritability and difficulty coping and functioning than adolescents who do not have an anxiety disorder.³ Agitation may develop more quickly and result in aberrant behaviors. Interactions that may increase the adolescent's anxiety, such as confrontation, should be avoided.

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A constant state of panic or feeling of restlessness, anxiousness, and irritability is not a typical aspect of adolescence. Anxiety can cause significant impairments in functioning and the adolescent patient's sense of well-being. In the most debilitating forms of anxiety disorders, psychiatric treatment is indicated.

Important goals for caring for adolescent patients who are experiencing anxiety include: [1,2](#)

- Determining whether the adolescent is experiencing fear or a normal anxious response to a given situation, versus whether he or she has an anxiety disorder or another psychiatric or medical disorder
- Intervening to help the patient relieve anxiety
- Evaluating the effectiveness of interventions

Recent research, such as the Child/Adolescent Anxiety Multimodal Study (CAMS), and a review of evidence-based practice, have found that adolescents with anxiety who were treated with cognitive behavioral therapy or medication, such as a selective serotonin reuptake inhibitor (SSRI) (sertraline), experienced favorable outcomes. [7,10](#)

Currently, certain SSRIs are approved by the Food and Drug Administration (FDA) only for obsessive-compulsive disorder or depression in children and adolescents. The risks and benefits of using medications to treat anxiety need to be considered, and informed consent must be obtained from parents and, if possible, the adolescent. SSRIs carry a black box warning for increased suicidality in children, adolescents, and young adults. If SSRIs are prescribed, the adolescent should be routinely assessed for suicidal thoughts and worsening of mood. The therapeutic effect of these medications may not be experienced immediately; however, studies indicate that the benefits of treatment outweigh the risks. [4](#)

Health care team members should consistently follow the adolescent patient's care plan, which should be individualized for the adolescent's specific issues, both medical and psychological. Adolescent patients should be included in the development of their care plans, and goals must delineate the actions necessary to achieve them.

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Inform the adolescent patient about his or her rights to privacy and confidentiality. Explain that in some instances (e.g., when abuse or harm to self or others is suspected), exceptions to confidentiality are made. Specific rules regarding confidentiality and adolescents can vary from state to state.
- Encourage parents to collaborate with the adolescent and health care team members to support the adolescent patient in making healthy treatment decisions.
- Educate family members about creating an environment that minimizes stress or aggravation.
- Educate the adolescent patient and family about the differences between norms at home and those in the acute care setting, and explain why differences are necessary. For example, an adolescent may play music before bed at home, but this may not be possible in the acute care setting. Look for ways to problem solve when a conflict arises (e.g., using headphones to listen to music).
- Instruct the adolescent patient in deep breathing and other grounding techniques (e.g., distraction, journal writing, reframing, reflection, positive self-statements) to manage anxiety.

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- Advise the adolescent patient and family members about the use and benefits of a sensory room if available.
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene before patient contact.
2. Introduce yourself to the adolescent patient.
3. Verify the correct adolescent patient using two identifiers.
4. Assess the adolescent patient's communication needs.
 - a. How does the adolescent communicate best—for example, by speaking or writing?
 - b. Does the adolescent speak a language other than English?
 - c. Which barriers to effective communication exist (e.g., emotional barriers, thinking distortions, misperceptions)?
5. Determine the level of stimulation in the adolescent patient's current environment.
6. Assess the adolescent patient's physical well-being, including current medical complaints, associated symptoms, and vital signs.
7. Assess the adolescent patient for the presence of anxiety or agitation related to his or her current medical condition.
8. Use an organization-approved standardized tool for suicide assessment.⁸
9. Assess the adolescent patient for an increased risk of self-harm or harm to others.
10. Assess the adolescent patient's current level of anxiety and determine the source, if possible.
11. Assess the adolescent patient's current coping skills and ability to use them while in the acute care setting.
12. Ask the adolescent patient which intervention is most helpful immediately during times of anxiety or distress.
13. Assess the adolescent patient for recent ingestion of toxins and for a history of substance use or abuse.
14. Determine the medications and dosages the adolescent patient currently takes.
15. Obtain information from family and close friends to assess the adolescent patient's typical responses, characteristics, and common coping mechanisms.
16. Assess the adolescent patient's family, academic, and social and sexual history, including sexual preferences and gender identification.
17. Screen the adolescent patient for sexual, physical, or emotional abuse and for peer-related bullying.
18. Assess the adolescent patient's habits, such as gambling, sexual activities, substance use, and eating patterns.
19. Assess the adolescent patient's family for current issues related to marital conflict, substance use or abuse, and underlying psychiatric disorders. (Parents may have difficulty caring for an ill child in the event of severe family dysfunction.)
20. Assess the adolescent patient for the presence of an underlying or comorbid psychiatric disorder.
21. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.

STRATEGIES

1. Perform hand hygiene.
2. Verify the correct adolescent patient using two identifiers.

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3. Explain the strategies to the adolescent patient and ensure that he or she agrees to treatment.
4. Establish a rapport with the adolescent patient.

Rationale: Establishing a rapport is a priority when working with adolescents. It facilitates assessment of the anxiety level, provides the adolescent with reassurance, engages the adolescent in a cooperative manner, and facilitates anxiety reduction.

5. Approach the adolescent patient in a calm, confident manner that demonstrates respect and concern, regardless of the adolescent's level of anxiety or agitation. Unless the adolescent is clearly out of control, avoid using authoritarian or excessively strict techniques.

Rationale: Appearing confident is reassuring, lends support, and helps establish boundaries for the adolescent. Adolescents are particularly sensitive to any communication or intervention that indicates disrespect, power, or control.

6. Monitor the adolescent patient's level of anxiety and note changes that may indicate increasing agitation. Use the least restrictive means necessary to establish reasonable and enforceable limits.

Rationale: Anxiety levels can change quickly, which may put the adolescent at risk for aberrant behaviors. The use of force or unreasonable consequences may be viewed as punitive or vindictive and can lead to increased agitation or aggression.

7. Reduce environmental stimuli that may increase the adolescent patient's anxiety level (e.g., overhead pages, a disruptive roommate, alarm bells). If possible, find a quiet room in which to meet with the adolescent.

Rationale: Moving to a quiet or private area provides increased confidentiality, removes observers, reduces the likelihood of shame or embarrassment for the adolescent, and decreases environmental stimulation.

8. Make inquiries into the adolescent patient's current perceived distress to determine the source. Use observational statements such as, "You seem worried," "It sounds like you're afraid," or "You look upset about something."

Rationale: The use of observational statements is less judgmental and more likely to be perceived as an attempt to understand the adolescent rather than as a negative view of the adolescent or an accusation. Identifying the source of distress allows statements of validation and empathy.

9. Ask the adolescent patient to assign a level to his or her distress using an organization-approved scale. Assure the adolescent that he or she is safe and that the feelings are temporary and should pass.

Rationale: Reliable assessment scales are accepted as a quantifier for adolescents to communicate pain and anxiety. When adolescents are

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reassured that their distress is temporary, they are more likely to help themselves and be receptive to interventions.⁷

Be aware that an adolescent patient experiencing extreme anxiety may be unable to rate distress and may become angry if pressured.

10. Use open-ended questions to elicit information about the source of anxiety.
 - a. Clarify statements that are ambiguous or superficial.
 - b. Pay attention to statements that indicate an increased risk of harm to self or others.
 - c. Express interest in the adolescent patient and allow the adolescent to have some control over the conversation.
 - d. Actively listen to the adolescent without interrupting or correcting.
 - e. Avoid statements that may appear judgmental, condescending, or dismissive.

Rationale: Techniques that encourage the adolescent to demonstrate self-expression without fear of reprisals, consequences, or judgments should be used. A nonjudgmental attitude encourages the adolescent to share personal information that may be the cause of the increasing anxiety.

11. Investigate medical complaints associated with anxiety as well as possible medical causes for increasing anxiety (e.g., drug overdose, intoxication, cardiac issues, hypoglycemia, hypoxia). Ask direct questions about potential medical issues.¹

Rationale: Medical complaints should never be assumed to be solely related to anxiety without proper investigation. Anxiety can be a symptom of some medical conditions (e.g., arrhythmias, low blood sugar, thyroid disorders). Anxiety can also produce physical symptoms (e.g., nausea, shaking, sweating).^{1,2}

12. Collaborate with the adolescent patient to develop a plan of care whenever possible. Encourage the adolescent to identify which behaviors or thoughts increase anxiety (e.g., "Things will never get better" or "This is really going to be painful").

Rationale: Involving adolescents in their own care empowers them and helps them gain knowledge and insight when they make healthy, successful decisions.

13. Use incidents of stress as teaching moments. Explore available resources in the current environment and at home, and teach techniques the adolescent can use to reduce anxiety.
 - a. Taking slow, deep breaths
 - b. Talking with someone
 - c. Soaking in a warm bath
 - d. Listening to soothing music
 - e. Taking a walk or engaging in other exercise
 - f. Meditating or praying
 - g. Writing in a journal
 - h. Using guided imagery
 - i. Avoiding anxiety triggers when possible

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Rationale: Identifying coping skills and encouraging their use empowers adolescents to regain control over their anxiety. The adolescent must be allowed to determine what is most helpful; for instance, he or she may prefer listening to music that would not be soothing to an adult.

14. Help the adolescent patient develop strategies for identifying sources of stress, understanding the connection between thoughts and feelings, and reducing anxiety.

Rationale: Caring for one's self is empowering for the adolescent.

15. Engage in problem-solving strategies that satisfy both the parents and adolescent patient. Do not take sides if a conflict exists.

Rationale: Taking sides with the parent or adolescent may increase anxiety and interfere with problem-solving.⁶

16. Help the adolescent patient identify anxiety triggers (e.g., blood draws, family meetings) before they occur.
17. Collaborate with the adolescent patient to establish a plan to keep anxiety at a manageable level.

Rationale: Having an established plan optimizes the likelihood that the adolescent will succeed at managing his or her anxiety. This strategy also strengthens the working relationship with the adolescent.

- a. Review the plan after it has been implemented (e.g., after the family meeting) and make necessary changes or adjustments.
- b. Acknowledge the adolescent's success in managing his or her anxiety.

Rationale: Reviewing the plan after implementation and making necessary changes before discharge is beneficial to the adolescent while he or she manages the anxiety. Commending the adolescent's success keeps him or her motivated and positive when adhering to the plan.

18. Be aware of developmental needs specific to adolescent patients, such as the need for privacy, the need to preserve dignity, and the need to have access to peers.

Rationale: Acknowledging the adolescent's developmental needs shows respect and understanding.

19. Perform hand hygiene.
20. Document the strategies in the adolescent patient's record.

REASSESSMENT

1. Assess, treat, and reassess pain.
2. Ask these questions when reassessing the adolescent patient:
 - a. Has the adolescent's anxiety been reduced?
 - b. Is the adolescent better able to manage his or her own anxiety?
 - c. Is an anxiety component indicated in the current care plan?

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- d. Are identifiable triggers communicated to all health care team members (e.g., during report, at hand-off communication, in the care plan)?
 - e. Is the adolescent participating in his or her care?
 - f. Does the adolescent have a clear understanding of expected behaviors and treatment goals?
 - g. Does the adolescent indicate a comprehension of expectations and limits?
 - h. Is the adolescent cooperating with expectations and limits?
 - i. Have all of the adolescent's needs or concerns been addressed?
 - j. Has an underlying medical condition been ruled out as the cause of the anxiety?
 - k. Have all unit health care team members been made aware of the adolescent with a history of anxiety?
3. If the adolescent patient has a history of anxiety reactions that involve agitation or aggression, conduct ongoing assessments throughout the adolescent's stay to monitor the effectiveness of the interventions and increased care.
 4. Ensure that all health care team members are aware of an adolescent patient at risk for self-harm or aggression, regardless of the underlying reason.
 5. Communicate strategies that help establish a therapeutic relationship with the adolescent patient to all health care team members to encourage consistency of care.
 6. Reassess the adolescent patient for anxiety-related issues at each shift change, if not more frequently.

EXPECTED OUTCOMES

- Early identification of adolescent patient with anxiety-related issues
- Safe and timely response to acute psychiatric issues
- Collaborative alliance with adolescent patient
- Demonstrated expectations
- Reduced or eliminated episodes of anxiety
- Self-care for managing anxiety
- Parental involvement in treatment and management of adolescent behaviors
- Collaboration with adolescent patient to identify acceptable solutions
- Safety maintained
- No attempted self-harm or aggressive behavior
- Trusting relationship with health care team members
- Follow-up care with a mental health professional

UNEXPECTED OUTCOMES

- Expectations not understood
- Unrecognized or unmanaged anxiety, escalating to agitation
- Continued escalation of behavioral issues
- Violence and threats to harm self, health care team members, other patients, or visitors
- Ineffective communication
- Failure to establish trusting relationship with adolescent patient
- Lack of collaboration with adolescent patient
- Lack of understanding of adolescent patient's concerns regarding unmet expectations
- Unsuccessful collaboration between parents and adolescent patient
- Exacerbation of behavioral issues
- No learning by the adolescent patient

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DOCUMENTATION

- Behavioral risk assessment
- Assessment findings of irritability, aggressive behavior, threats, and assaultive behaviors²
- History of legal problems
- Self-harm assessment findings
- Inappropriate sexual behaviors
- Mental status assessment (e.g., mood, affect, orientation, speech, behaviors, socialization)
- Uncooperative behaviors, including verbal and nonverbal threats
- Interventions used to manage uncooperative behaviors
- Expectations and limits clarified and explained as part of education
- All persons involved in interventions
- Status change (e.g., one-to-one, change in the level of care)
- Medical issues and resulting consults and treatment
- Notification of family, practitioner, mental health services, police, or other emergency services, if indicated
- Incident report and other reports required by the organization or law enforcement, if necessary
- Education
- Successful interventions for managing anxiety
- Adolescent patient's response to interventions
- Substances and quantity of drugs, medications, or alcohol used, if indicated; length of time of drug, medication, or alcohol use; pattern of usage and previous withdrawal and severity
- Vital signs
- Signs and symptoms of withdrawal
- Consequences of substance use
- Referral to addiction specialist, treatment center, mental health professional, or other outside support group, such as Alcoholics Anonymous[®]
- Unexpected outcomes and related interventions

SPECIAL CONSIDERATIONS

- When considering interventions, know the adolescent patient's current medications and their relationship to the adolescent's behavior.
 - Is the adolescent currently taking medications to manage behavioral problems?
 - Do the medications minimize or exacerbate behavioral issues?
- When creating the adolescent patient's care plan, consider consultation with mental health services, if indicated (e.g., behavioral issues, suicidality, self-injury, psychosis, anxiety disorders).
- Emotionally or socially immature adolescent patients require assistance with understanding limits and expectations regarding inappropriate expressions of anxiety and other behaviors. Adolescent patients frequently need to have limits that establish and reinforce cultural norms and acceptable behaviors for their age and the current environment.
- Parents should be involved with communicating expectations for adolescent patients who need limit setting.
 - At minimum, the parents should be aware that their child will be educated about his or her expected behavior.

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- Some parents may have strong negative feelings about other adults setting limits for their child.

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*In these skills, a “classic” reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

Elsevier Skills Levels of Evidence

- Level I - Systematic review of all relevant randomized controlled trials
- Level II - At least one well-designed randomized controlled trial
- Level III - Well-designed controlled trials without randomization
- Level IV - Well-designed case-controlled or cohort studies
- Level V - Descriptive or qualitative studies
- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

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