Managing patients’ anxiety about planned medical interventions

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None declared

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Abstract
Patients are often anxious about planned medical interventions, and those experiencing anxiety are less likely to have the confidence to collaborate with healthcare professionals on their plan of care, and make decisions about consent. They may also find it challenging to follow rehabilitation guidelines, which can affect their long-term recovery. As part of their professional duty, nurses are required to recognise when people are anxious or in distress and respond compassionately, and while acquiring valid consent for any planned medical intervention requires the nurse to explain any risks, they should also attempt to reassure patients. The anxiety that precedes a planned medical intervention has been described as state anxiety; this refers to feelings of discomfort and uncertainty that accompany a situation such as an operation or a diagnostic procedure. Nurses can attempt to reduce any anxiety that patients experience by explaining the planned medical intervention and providing accurate information at the optimum time. This article outlines some of the coping theories that nurses can use to support patients in managing their anxiety about planned medical interventions.

Keywords
coping strategies, patient anxiety, patient outcomes, planned medical interventions, state anxiety

Aims and intended learning outcomes
The aim of this article is to enhance nurses’ understanding of the way patients can be affected by anxiety before planned medical interventions, which might include investigative procedures and operations. Nurses should support patients based on a comprehensive understanding of the causes and symptoms of their anxiety and the various coping strategies. The time out activities in this article are designed to assist nurses to reflect on previous experiences with patients who were anxious and to explore various approaches to anxiety management. After reading this article and completing the time out activities, you should be able to:
- Explain why it is important for nurses to review their understanding of patient anxiety.
- Define anxiety and the relevant coping strategies.
- Outline how people learn to process stimuli and define certain situations as threatening.
- Understand the interventions that can support patients in reducing anxiety associated with planned medical interventions.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:
It emphasises that planned medical interventions can cause patients to experience anxiety. This relates to the theme of prioritising people by recognising when patients are anxious or in distress and responding compassionately and politely. The Code states that nurses must communicate clearly, in a way people in their care understand. This article outlines how any information provided about a planned medical intervention should be relevant to the patient’s needs and delivered in an appropriate format.

It outlines how nurses should listen to patients and seek to understand the triggers that may increase their anxiety. This relates to the theme of prioritising people by acting in partnership with those receiving care, supporting them to access relevant health and social care information and assistance when required.

As part of the theme of prioritising people, The Code states that nurses should make sure they receive informed consent from the patient and document this before undertaking any procedures. The article outlines how providing accurate information can assist nurses in obtaining consent from patients for planned medical interventions.

**Introduction**

Anxiety can be defined as an emotional defence response to stimuli that threaten a person’s safety or well-being (Cooper 2014). It is closely associated with the stress response often referred to as ‘fight or flight’, which includes increased heart and respiratory rate, and transfer of blood to the muscles (Lovallo 2015). Anxiety may be associated with actual threats or may arise because of an individual’s beliefs about what could happen (Cooper 2014). The function of anxiety is to prompt the individual to remove themselves from danger or alert them to any risks.

Healthcare interventions, including invasive procedures and diagnostic tests, which can cause discomfort as well as potentially confirming a diagnosis such as cancer, can act as triggers for anxiety.

(Frojd et al 2007, Goldberger et al 2011, Kushnir et al 2012, West et al 2014). Intimate procedures, such as cervical screening, can be especially anxiety-provoking (Jones 2013), as can the use of anaesthetics, which represent a temporary loss of control (Mitchell 2009). The extent to which people experience anxiety varies (Lovallo 2015). For example, a patient with a learning disability could be particularly anxious about a forthcoming operation, not because they are predisposed to anxiety, but because they find processing healthcare information challenging (Harris 2015). Similarly, the life-changes resulting from certain surgical procedures might be greater than some patients feel able to manage.

State anxiety refers to feelings of discomfort and uncertainty that arise in response to a situation outside the individual’s usual experience. Invasive procedures and tests have the potential to provoke state anxiety, especially if they are associated with a potentially life-changing diagnosis (Bailey 2010). The Code states that nurses must communicate clearly, in a way people in their care understand. This article outlines how any information provided about a planned medical intervention should be relevant to the patient’s needs and delivered in an appropriate format.

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TIME OUT 1

Reflect on a patient whom you supported to prepare for a planned medical intervention. How anxious did they seem and what factors influenced their anxiety? Was the level of anxiety constant or did it peak at any point?
**Anxiety**

It is important to differentiate between physiological stress and anxiety. Selye’s (1978) theory of general adaptation syndrome described how the body responds to stressors (physically or psychologically unpleasant stimuli) through the autonomic nervous system, which is responsible for the body’s involuntary systems such as breathing, digestion and heart rate, and which maintains internal homeostasis. However, anxiety refers to the emotional experience of stress, including the processing of memories that either sustain the stress response and increase anxiety, or enable the body to return to a relaxed physical state. Anxiety is closely associated with memory and learning, and the ascription of meanings to stimuli (Martin et al 2009).

Humans receive external information via the senses, such as sight, touch and smell, and these stimuli are passed via the sensory cortical processing regions, such as the visual cortex, to areas of the brain known as amygdalae, which are involved in representing the stimuli as either a threat or reward (Figure 1) (Charney and Drevets 2002, Martin et al 2009). The amygdalae play a significant role in the development of emotional intelligence, memory processing, decision-making and the appraisal of threats (Amunts et al 2005).

The left amygdala produces feelings of reassurance, which can promote a desire for a particular stimulus (Murray et al 2009). The right amygdala is associated with fear and the processing of threatening stimuli, as well as connecting time and place (context) to emotional challenges, for example the patient may come to associate the unpleasant side effects of an intravenous infusion containing cytotoxic drugs as threatening, even though its purpose is ultimately beneficial (Markowitsch 1998). Right amygdala reactions are predominant in individuals who have been exposed to repeated threatening stimuli over time.

Memory-processing is another important function of the amygdalae. Long-term memories are not created immediately after an event; instead, a series of short-term memories associated with either pleasant or unpleasant experiences accumulate over time. The amygdalae connect the experience of events with emotions, which inform the interpretation of future experiences (Blair et al 2001), as well as deciding whether an experience is memorable and worthy of further attention, for example ‘seeking’ or ‘avoiding’ behaviours. Rewarding stimuli are recognised and sought out, whereas threatening stimuli are avoided. However, individuals can become sensitised to unpleasant stimuli and habitually interpret these in negative terms, which means that challenging experiences can predispose them to view future events as threatening. Charney and Drevets (2002) described how people learn to fear situations where unpleasant stimuli, known as conditioning stimuli, overpower positive stimuli, known as unconditioning stimuli.

**TIME OUT 2**

Reflect on the patient profile you summarised in Time out 1 and ask yourself why a planned medical intervention might have made the patient anxious?

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**Figure 1. Pathway of stimulus, perception and anxiety**

The patient is subject to external stimuli, such as a letter informing them that a medical intervention is required.

The brain draws on previous memories of medical interventions to define them as threatening or rewarding. Patients are more or less predisposed to anxiety dependent on their memories.

The patient uses their preferred coping strategies, for example, they might seek out more information about the intervention or attempt to distract themselves from it.

Potential meanings ascribed to planned medical interventions:

- ‘This operation will work’
- ‘This will hurt’
- ‘I won’t survive’
- ‘I have to trust them’

(Adapted from Charney and Drevets 2002)
How thoroughly did you explore the patient’s perceptions of the forthcoming intervention? Did you prepare the patient in a way that was individual to them?

The brain processes stimuli in emotional terms. For example, the insertion of an intravenous cannula to donate blood may be interpreted positively since it is to be used to assist others; however, a cannula inserted to deliver a cytotoxic drug may signify that the body is vulnerable, and be perceived negatively. Charney and Drevets (2002) explained that the brain’s processing of stimuli is:

- Evaluative – something desired versus something feared.
- Expressive – the requirement to act in some way.
- Experiential – provoking feelings about status, for example powerlessness.

What is significant about the way the brain processes stimuli and the associations with emotions such as pleasure or anxiety, is that these develop over time, building incremental attitudes towards unfamiliar situations such as a planned medical intervention. For example, multiple childhood visits to the dentist, while not all resulting in pain, can, over time, become associated with feelings of vulnerability.

The confidence of patients to manage events such as planned medical interventions varies and is dependent not only on their capacity to process new, often technical information (reasoning ability), but also their ability to interpret any information they receive as reassuring.

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Anticipated pain of a needle biopsy, but could also focus on what the biopsy might reveal. Mitchell (2009) described how a patient may be anxious about whether a surgeon could be trusted not to hurt them. Acuff et al (2014) found that patient anxiety associated with computerised tomography scanning related to the need for some means of communicating with staff during the procedure, such as the use of a call device. It is important for nurses to remember that the prospect of a planned medical intervention can trigger uncomfortable memories of past events, for example Jones (2013) observed how cervical screening could cause traumatic memories of a previous sexual assault to resurface.

**TIME OUT 3**

Reflect on any experience in your life that may have predisposed you to consider medical interventions as threatening. Have any of these predispositions been reinforced or countered in any way? How could you use this knowledge when patients ask you questions about their planned medical interventions?

**Coping strategies**

Once the right amygdala has alerted the individual to a perceived threat and connected any new stimuli to previous memories, the person may begin to experience anxiety. While people have little opportunity to manage the threat of sudden trauma, a planned medical intervention allows them time to anticipate any challenges and become anxious. The optimum measures for allaying the patient’s anxiety are those that consider the patient’s coping strategies, for example a patient might prefer to be distracted from a procedure by discussing the daily news, whereas focusing on any impending discomfort would accentuate their anxiety. Lazarus and Folkman (1984) described two approaches to coping:

- Problem-focused coping – involves the management of the threat itself. In some instances, this approach is suitable for patients scheduled to undergo planned medical interventions, who may, for example, be permitted to choose an alternative form of anaesthesia, which
gives them a sense of control, thus modifying the threat.

» Emotional-focused coping – involves supporting the patient to adjust their emotional response to the threat. The perceived threat, such as a necessary operation, remains, but the patient attempts to redefine their attitude to it. For example, the patient may repeatedly remind themselves that the intervention is routine, while the nurse may assist them by identifying that other patients who have undergone the same intervention have recovered. A patient who attempts to redefine their reaction to a planned medical intervention in this way is responding at an emotional level with an adaptive approach. However, emotional-focused coping does not always sustain the patient’s ability to manage anxiety; for example, a patient who consumes alcohol excessively leading up to a planned medical intervention may be able to mask their anxiety to some extent, but will not have dealt with its root cause.

Weiten and Lloyd (2009) described a person’s ability to redefine a perceived threat as appraisal-focused coping, which involves the patient challenging their assumptions about the threat. For example, patients beginning a course of chemotherapy, which might require successive treatments, may be able to envisage the treatment as an opportunity to learn about their new circumstances (Geiger 2015).

As a result of the time pressures involved in modern healthcare, instead of investigating how the patient prefers to manage stressful incidents, nurses often attempt to reduce the patient’s anxiety by providing information on what the planned medical intervention entails. Bailey (2010) identified some of the concerns of patients who are about to undergo surgery, for example loss of control, lack of information about what the intervention entails, and the perceived impersonal nature of the process. Patients are often provided with information that maps out the sequence of events, such as which procedures will be performed in what order, where the intervention will be undertaken, and where the patient will find themselves once the intervention is complete. However, in practice, there is no typical patient and no standard set of anxieties that arise before a planned medical intervention begins. Baker (2011) recommended that, rather than simply providing information, nurses should support patients to manage their anxiety in other ways, for example explaining commonly used words, such as ‘investigate’, ‘examine’, ‘consult’ and ‘refer’, which might not be clearly understood by the patient. To further personalise care, Baker (2011) recommended the use of the acronym AIDET (Box 1).

TIME OUT 4
Reflect on a patient in your care who was anxious about a procedure. Can you think of a way that you might have been able to support them to redefine their attitude to the procedure? How do you think you might have done this?

Managing anxiety
Nurses allaying any anxiety the patient might experience should attempt to override

<table>
<thead>
<tr>
<th>BOX 1. AIDET acronym for the personalisation of care</th>
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<tr>
<td>A: acknowledge the patient, addressing them by name.</td>
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<tr>
<td>I: introduce yourself, explain what you do and what your role is. It is important to remember that patients will have varying experience of healthcare and some may be more anxious than others.</td>
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<tr>
<td>D: duration. Support the patient to assess how long they should wait for attention and how long any procedure might take. Even if the assessment is not entirely accurate for reasons beyond the control of the nurse, offering an estimate signals an interest in the patient’s concerns.</td>
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<tr>
<td>E: explain the procedure, not only in terms of what will happen, but what this might feel like. Derman et al (1983), outlined how little attention was paid to what interested patients most about their tracheostomy care, such as how the procedure would feel.</td>
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<tr>
<td>T: thank the patient for allowing you to assist them. This signals the primacy of their control and that you are providing for their needs. Whatever details are shared about a procedure, patients are mainly concerned with whether the nurse respects them and whether they will listen to the patient’s reports and requests.</td>
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(Adapted from Baker 2011)
any stimuli that trigger discomfort with reassuring stimuli, balancing the potential risks of a planned medical intervention with information concerning successful outcomes and any support available. Similarly, the patient’s attention can be diverted from the elements of the procedure that concern them most, for example the nurse could describe the potential pain of an impending injection as a ‘small scratch’ before proceeding quickly. In this instance, the patient’s anxiety about the pain is minimised and the procedure successfully completed before they have an opportunity to focus on the pain. Given the often limited contact time available for nurses to interact with patients, two support approaches – providing information and distraction – have dominated the literature on managing anxiety before a planned medical intervention.

Providing information
Providing information can reduce patients’ state anxiety. Patients who manage their anxiety by focusing on the nature of the threat and what could be done to limit it, can often be reassured by the provision of detailed information about the planned medical intervention, overriding cues that might prompt alarm (Kim et al 2014). Before information is used to relieve patients’ anxiety, nurses should decide which information may be shared, by whom and in what format. Providing detailed information about a planned medical intervention can also assist patients in providing consent by outlining the relevant clinical details, as well as supporting them in relation to any anxiety about their recovery and rehabilitation.

The amount of information required to reassure an individual is determined by their preferred coping strategy. A patient who prefers to manage an anxiety-provoking situation by finding out as much as possible about it, may welcome detailed-provoking information about a planned medical intervention (Kim et al 2014). For example, a patient dealing with a cancer diagnosis may benefit from an understanding of how future treatment will be shaped by the staging of the tumour (Frojd et al 2007). Information about any likely discomfort and the measures used to control it are particularly important (Humbyrd et al 2016), as is outlining what will take place during the planned medical intervention, where it will be performed, and what factors will indicate that it is proceeding according to plan. Patients may also benefit from the knowledge that the planned medical intervention has been performed frequently and that the clinician undertaking the intervention is an expert in the field; similarly, the patient may be reassured by understanding the likely outcomes (Bailey 2010).

Patients may find it reassuring to receive information about a planned medical intervention from the healthcare professionals who will undertake the procedure, such as the surgeon or anaesthetist (Bailey 2010). This type of personal consultation enables the patient to ask questions about the intervention. Similarly, a healthcare professional who expresses interest in the patient’s concerns may reassure them (Bailey 2010). Goldberger et al (2011) studied a group of patients undergoing diagnostic cardiology procedures who were provided with information in either oral or written form, or on video. Researchers found that each of the approaches had a positive effect on patients’ anxiety levels, however, while oral delivery of information was considered effective it was also time-consuming, whereas video presentation of information enabled patients to view the procedure as a series of manageable steps.

TIME OUT 5
Reflect on the information about a planned medical intervention you provided for a patient recently. Did the way you presented the information support them in managing their anxiety, or do you think an alternative approach might have been more effective?

As well as providing patients with the most appropriate information, nurses should identify the optimal time to share it. Pokharel et al (2011) studied 188 Nepalese patients who were about to undergo a planned medical procedure...
and demonstrated that highly anxious patients sought reassurance by requesting additional information and that their anxiety became increasingly apparent at certain stages, reaching a peak on the morning of the operation and falling immediately before the provision of anaesthesia. While the administration of pre-procedural medications might explain some of the reduced anxiety levels observed in this study, Pokharel et al (2011) speculated that patients reach a point where they have emotionally committed to a procedure and accept that it is necessary.

In the author’s clinical experience, the nurse should consider providing information about a patient’s planned medical intervention before their hospital admission, and before their anxiety levels have risen to the point where they become challenging for the patient. However, the patient might experience recurring anxieties about the planned medical intervention and the nurse may have to consult them on the days leading up to the intervention, and particularly on the day of the intervention itself, to answer any further questions (Pokharel et al 2011).

Distraction
Another method of support involves distracting the patient from their anxieties by providing sensory stimuli, which the patient’s brain has learned to associate with less threatening circumstances and which aim to persuade them that events are proceeding as expected (Fenko and Loock 2014, Lovallo 2015). These stimuli may include music or the provision of ambient scents during an intervention (Fenko and Loock 2014); similarly, the nurse may discuss other topics while the intervention is undertaken. This distraction approach may be suited to patients who have been described as ‘distraction copers’ or those who prefer to pay less attention to threats by focusing on other factors (Kim et al 2014).

Another principle of the distraction technique is that while enough information should be provided to obtain the patient’s consent to the planned medical intervention, excess information is avoided. While the patient may accept that certain risks must be acknowledged as part of the informed consent process, they may not wish to know the detail (Hopko and Lejuez 2008).

McLeod (2012) evaluated the effects of music on patient anxiety in a minor plastic surgery outpatient department. During the operations, 40 of the 80 participants listened to music that they had selected from a menu; the other 40 participants underwent procedures without music. McLeod (2012) found no statistically significant difference in anxiety levels between the two groups and even though the first group had chosen their preferred music, this did not reduce their anxiety scores.

Tsai et al (2014) reviewed the evidence for the effects of music on the anxiety of patients with cancer, concluding that music reduced the anxiety for adult patients with cancer, but was less effective in children and adolescents. The researchers suggested that because children and adolescents had less experience of healthcare environments and understanding of the procedures, music was less likely to distract them.

Fenko and Loock (2014) studied the influence of ambient scent and music on patient anxiety in a plastic surgeon’s waiting room, observing that both ambient scent and music reduced patient anxiety, but that they were more effective when used separately. While patients might be familiar with the use of scent on entering supermarkets, for example, or background music in a dental waiting room, patients stated that the use of both in a clinical setting was contrived.

TIME OUT 6
Reflect on your use of distraction when performing a clinical intervention such as dressing a wound or undertaking catheterisation. What do you talk to the patient about after briefing them on what the intervention entails? Do you provide a commentary on your actions, or do you discuss other subjects?

Research on the use of conversation to distract patients during interventions is limited. Bulas (2011) outlined the importance of healthcare professionals explaining interventions to patients...
in technological environments such as radiology. Mourad et al (2011) found that patients who had been referred to a medical centre for interventions including lumbar puncture were reassured by information provided by healthcare professionals, while McCarthy et al (2013) described how patients and healthcare professionals in one emergency department spent a significant amount of time providing each other with information. However, both studies focused on patient satisfaction and the type of conversations that took place, rather than whether they distracted patients from planned medical interventions.

A study by Major and Holmes (2008) recorded three nurses’ conversations with 23 patients on a hospital ward, and found that effective communicators could secure ongoing consent for planned medical interventions as well as those that were already underway. The researchers also noted that the nurses used ‘social talk’, such as reference to the weather or recent news, to establish rapport with patients and support them through periods of anxiety.

**Conclusion**

Patients who experience anxiety associated with planned medical interventions may find it challenging to undergo required procedures. Nurses should attempt to establish whether a patient is prone to anxiety so that

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**References**


attention can be focused on providing or supporting appropriate coping strategies. By understanding what makes individual patients anxious, nurses will be better able to reassure them by providing targeted information. While it may be necessary to perform the planned medical intervention, patients’ experience can be improved if nurses provide clear guidance about how the intervention will proceed.

To assist patients in reducing their anxiety, it is important for nurses to ascertain whether patients would prefer to receive a significant amount of detail about the planned medical intervention or would rather be provided with the minimum necessary detail to allow for informed consent. Some patients might also prefer to manage their anxiety by being distracted from the realities of the planned medical intervention. When attempting to manage a patient’s anxiety about a planned medical intervention, the nurse’s use of information should always be determined by the patient’s preferred coping strategy.

TIME OUT 7
Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their practice. Consider how understanding a patient’s anxiety regarding a planned medical intervention relates to the themes of The Code.

TIME OUT 8
Now that you have completed the article, you might like to write a reflective account as part of your revalidation.

References

RCN Rheumatology Nursing workshop 2018
‘Rheum with a view’

Friday 12 January 2018
RCN Headquarters, 20 Cavendish Square, London W1G 0RN

This workshop is based on the results of a forum survey which asked you to identify issues relating to the management of rheumatological disease, interventions, treatment and support.

The aim is to address these issues as well as developing the unmet need of clinical leadership skills and personal and professional resilience. This event will enable specialist nurses to continue to deliver excellent care, follow best practice and inspire colleagues despite continued NHS barriers and difficulties.

This is critical to enable robust analysis of roles and responsibilities while specialist nursing banding is being reviewed on a national scale.

What topics will be covered?
- patient fatigue
- pain
- leadership and resilience training
- psychological impact of chronic disease
- Biosimilars update and how they impact on practice
- Rheumatology Specialist Nursing Competency frameworks.

Visit www.rcn.org.uk/Rheumatology18

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Patients’ anxiety about planned medical interventions

TEST YOUR KNOWLEDGE BY COMPLETING THIS SELF-ASSESSMENT QUESTIONNAIRE 903

1. Anxiety can be defined as:
   a) An emotional defence response to stimuli that threaten a person's safety or well-being □
   b) A physiological state that results in a ‘fight or flight’ response □
   c) A physical reaction that includes high blood pressure, release of adrenaline and increased alertness □
   d) Impaired awareness of external threats □

2. Triggers for anxiety may include:
   a) Diagnostic tests □
   b) Invasive procedures □
   c) Procedures involving the use of anaesthetics □
   d) All of the above □

3. What does the term 'state anxiety' refer to?
   a) Apprehension or fearing hospital admission □
   b) Feelings of discomfort that arise in response to a situation outside the individual's usual experience, such as invasive procedures or diagnostic tests □
   c) Feelings of anxiety concerning specific medical procedures □
   d) A form of anxiety that has no obvious connection to any stimulus □

4. Which of the following is not a function of the autonomic nervous system?
   a) Breathing □
   b) Digestion □
   c) Conscious decision-making □
   d) Heart rate □

5. The areas of the brain known as the amygdalae are involved in:
   a) Representing external stimuli as either threats or rewards □
   b) Activating the ‘fight or flight’ response □
   c) Reducing the amount of adrenaline the body produces □
   d) Activating the release of testosterone in response to danger □

6. The brain’s processing of stimuli is:
   a) Evaluative □
   b) Expressive □
   c) Experiential □
   d) All of the above □

7. Which approach to coping involves supporting the patient to adjust their emotional response to a threat?
   a) Emotional-focused coping □
   b) Strategic coping □
   c) Anxiety-based coping □
   d) Support-based coping □

8. In appraisal-focused coping:
   a) The patient identifies potential stressors □
   b) The nurse provides the patient with a list of commonly used techniques to manage anxiety □
   c) The nurse and patient work together to develop a coping strategy □
   d) The patient challenges their own assumptions about a threat □

9. Which of the following is a recognised technique for reducing anxiety?
   a) Diverting the patient’s attention away from anxiety-provoking elements of a planned medical intervention □
   b) Focusing on technical elements of the intervention □
   c) Avoiding any discussion of the intervention □
   d) Scheduling the intervention at a time of the patient’s choosing □

10. Which of these techniques can be used to distract patients from their anxiety?
    a) Ensuring that Wi-Fi is available in all clinical settings to enable patients to access personal electronic devices □
    b) Asking patients to write down their memories of previous planned medical interventions □
    c) Asking relatives not to accompany patients to the hospital or clinic □
    d) Playing ambient music in waiting areas □

How to complete this assessment

This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 53. There is one correct answer to each question.

- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 2 August.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically. Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

You may want to write a reflective account based on what you have learned. Visit rcni.com/reflective-account

This self-assessment questionnaire was compiled by Jason Beckford-Ball

The answers to this questionnaire will be published on 2 August

Answers to SAQ 901 on effective handovers, which appeared in the 5 July issue, are:

1. c  2. d  3. b  4. c  5. a  6. d  7. a  8. a  9. b  10. b