NURSING DIAGNOSIS: DIFFERENTIATING FEAR AND ANXIETY *

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As the concept of nursing diagnosis is increasingly introduced and implemented in nursing practice, many different challenges and issues will emerge for nurses. One such challenge is the fact that the accuracy of the nursing diagnosis of a presenting condition and the factors contributing to its existence, intensity and duration is prerequisite for effective nursing intervention. Yet, inherent in the diagnostic process is the difficult nursing task of differentiating which label accurately describes aspects of the client's state of health.

The process of accurate diagnosing is complicated and is fraught with many possible pitfalls, especially in view of nursing's early developmental stage and currently limited diagnostic sophistication (Field 1979, p. 501). Aspinall and her colleagues (Aspinall 1976, 1979; Aspinall, Jambruno and Phoenix 1977) have described nursing literature as containing significant gaps in regard to guiding the nurse in the diagnostic process, which is often portrayed as a simple, clear-cut and almost automatic step in the nursing process. From the findings of two investigations of the diagnostic process in nursing, Aspinall (1976, 1979) has concluded that many nurses have difficulty with this process and more specifically are "unable to utilize knowledge in the process of making a differential diagnosis of a symptom" (Aspinall 1979, p. 185). However, her research has also shown that nurses can be assisted to make better use of knowledge in evaluating clinical evidence.

Kelly (1964) suggested one possible source of inaccuracy in the diagnostic process used by nurses, i.e. the value which nurses place on certain subjective or objective patient data. She stated that "if a nurse places too much reliance on a sign or symptom that has little or no validity, or if she ignores a clue with high validity, her achievement (inferential accuracy) will be low" (p. 320). During a recent investigation, briefly described below, the data suggested that nurse-participants appeared to place low value on verbal expressions by clients about their experience of fear. This observation led to further examination of the available data and to consideration of the differentiation between fear and anxiety.

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This paper describes the project and the data related to differential diagnosing of fear and anxiety; summarizes aspects of the search of selected literature; and explores the implications for nursing care of clients experiencing either human response.

PROJECT DESCRIPTION

A brief description of the research design and central findings of the project, "An Investigation of the Definition of Nursing Diagnoses"[1], provides the background for the curiosity-provoking findings. The findings are reported in full elsewhere (Jones and Jakob 1980). The study involved the participation of 57 volunteer practising nurses, with the aim of discovering how the nurses describe the human responses for which they give care, i.e. the phenomena of nursing diagnoses and the factors associated with them.

A prepared list of nursing diagnoses (Jones and Jakob 1977, pp. 82, 83) was given to volunteer participants who used it in identifying the diagnoses of up to ten clients for whom they were giving care. Advanced nurse-clinicians (experienced nurses with baccalaureate or master's degrees) participated. The data-collection tool, designed and pretested in an earlier phase (Jones and Jakob 1977), also requested information about the nurses, the clients, and the nurses' opinions about the list of diagnosic terms. The submitted nursing diagnoses were accompanied by descriptive modifiers of intensity, duration, contributing factors and substantiating observations of behaviour.

The two investigators separately reviewed each identified diagnosis, verified that it was appropriate according to the project's definition of a nursing diagnoses, and that it was supported by the subjective or objective information provided. A nursing diagnosis was defined as the statement of a person's response to a situation or illness which is actually or potentially unhealthful and which nursing intervention can help to change in the direction of health (Mundinger and Jauron, 1975). Items which did not meet those criteria were deleted from the pool of diagnoses. In some instances, participants provided data that clearly indicated the presence of an unidentified diagnosis and the investigators added it. In other instances, participants identified a phenomenon with one label that would be named more accurately by another diagnostic label and the investigators revised it. Lastly, if a participant presented a newly-coined diagnostic label which duplicated the intent of a label from the project's diagnostic list, the investigators re-labelled it. As a result of the review process, approximately 66 per cent of the total diagnoses were identified by the participants, and 23 per cent were added, 10 per cent were revised and 1 per cent were re-labelled by the investigators. Data from all of the 57 nurse-participants on 393 clients generated 2,517 nursing diagnoses.

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As Table 1 shows, "fear" was the third most common single diagnosis occurring. The 131 instances of fear were described as being related to 293 contributing factors, or a mean of 2.2 identified factors per diagnosis of fear. "Anxiety" is shown as the seventh most common single diagnosis occurring; 98 instances of anxiety were related to 205 contributing factors, or a mean of 2.1 factors.

Table 1. Outcome of Review Process: Frequency and Percentage Distribution of Eleven Most Frequently Reported Nursing Diagnoses

Nursing Diagnosis	No.	%
Mobility impairment	198	7.9
Self-care activities: alteration in ability to perform hygiene	133	5.3
Fear	131	5.2
Pain	125	5.0
Skin integrity impairment	102	4.1
Nutritional alteration: Less than required	99	3.9
Anxiety	98	3.9
Family relationships impairment	93	3.7
Communication process impairment	88	3.5
Self-concept alteration: Role/Identity	82	3.3
Self-concept alteration: Body image	79	3.1
All Others	1,289	51.1
Total	2,517	100.0

SOME PUZZLING RESULTS ABOUT FEAR

As indicated, a total of 131 instances of fear were confirmed by means of the project's review process. The respondents submitted 65 instances, only 3 of which were unsupported by the accompanying data. In other words, when the nurse-participants labelled a clinical phenomenon as fear, the two project investigators concurred 95 per cent of the time (compared with 86 per cent overall), a high degree of agreement for these 65 submitted diagnoses. This was felt to be an encouraging indication of the clarity and appropriateness of the label, which seemed to be useful in the real world of clinical nursing. Paradoxically, the remaining results of the review process were puzzling, to say the least.

Despite the high level of agreement regarding the 65 submitted diagnoses of fear, a further 69 instances (52.7 per cent of the total instances of fear) emerged from the review process, 41 revised from other categories and 28 added by the investigators. These data are summarized in Table 2.

Table 2. Outcome of the Review Process for All Instances of Fear

Review Process Manipulation		No.	%
Submitted by nurse participants		65	47.3
Deleted by investigators	(−)	3	n.a.
Revised from another diagnosis		41	31.3
Added by investigators		28	21.4
Total		131	100.0

The unexpected rate of revision was recognized early in the review process when it became apparent that some instances of "anxiety" were being revised to "fear". At this early stage, the definitions of the two diagnostic labels were discussed by the investigators in order to confirm agreement about discrimination. Fear was defined as a client-expressed or client-confirmed response of focused apprehension toward the presence of a recognized, usually external threat or danger to one's limb, autonomy, self-image, or community with others. On the other hand, anxiety was defined as a vague, uneasy sense of worry, nervousness, or anguish which is a reaction to an anticipated (often non-specific) danger to one's expectations; needs for prestige, status, and esteem, or need to confirm one's prevailing self-views. Unrecognized or repressed fears or conflicts and interpersonal transmission were seen to contribute to the formation of anxiety. The critical aspect which differentiated fear from anxiety was seen to be the client's awareness and identification of the object of dread or apprehension.

Further examination of the original data sheets containing the revisions yielded even more interesting results. All but two of the 41 revised instances were indeed changed to fear from anxiety and Table 3 summarizes the characteristics of related supporting data for these 39 instances.

Table 3. Characteristics of the Supporting Data in Instances of "Fear" which Were Revised by the Investigators from Nurse-Participant Submissions of "Anxiety"

Type of Supporting Data	No.	%
Contained the words "frightened", "scared", or "afraid"	9	23
Implied a high probability of the presence of fear	23	59
Implied a moderate probability of the presence of fear	7	18
Total	39	100

As can be seen in Table 3, in nine instances the nurse supported the diagnosis of anxiety with subjective and objective information which included specific statements by the client using the words "frightened", "scared", or "afraid". In a further 23 instances, the supporting data implied a high probability of the presence of fear rather than anxiety. These supporting data often were in the form of quotations from patients couched in questions or statements and accompanied by nurse observations. Examples included:

> a man acutely ill with heart disease who is apparently terrified that he may worsen his condition by moving: he "doesn't initiate any activity (even minor) without questioning if it's alright".
>
> a new mother apparently afraid that she may be unable to sufficiently nurse her baby during a growth spurt and thereby adversely affect its health: she "verbally expressed anxiety about her abilities to nurse and about the baby's health".
>
> A young woman apparently afraid that she is undesiredly pregnant: she's "worried; wringing hands, tense".

Examples of the supporting data felt by the investigators to be indicative of a moderate probability of the presence of fear as opposed to anxiety (7 instances) were:

> a man awaiting an impending cardiac catheterization with apparent fear: he "fantasized that the future will be OK".
>
> a man post-amputation awaiting hospital discharge and apparently afraid that he will not be able to manage at home: " 'How will I manage at home?' Plaintive tone of voice, frowning".

Finally, of the 28 instances of fear added by the investigators (Table 2), 21 were identified from data sheets containing client quotations with the words "afraid", "scared", or "frightened".

REVIEW OF SELECTED LITERATURE

Before considering any explanation of the paradoxical situations just described, selected literature about fear was reviewed. It was interesting to note that the earlier volumes of the *Cumulative Index to Nursing and Allied Literature* (Seventh Day Adventist Hospital Association 1956-1968) contain the following reference at the end of the listings under the subject heading of Fear: "see also, Anxiety". From 1969 to 1972 that same cross-reference was placed under the subject heading of Fear, before the listing of any articles. After 1972, no mention of Anxiety is made as a possible cross-reference for fear. These reference changes within the index suggest an evolution in the differentiation of the concepts of anxiety and fear within nursing. In addition to perusal in nursing resources, inquiry was also made through selected literature in the disciplines of psychology and psychiatry.

Johnson's comments about anxiety can effectively introduce the ambiguous characterization of anxiety: "Anxiety is perhaps the most frequently appearing phenomena in psychological literature. Its theoretical and operational definitions are laden with semantic confusion. This has led to vague and interchangeable use of the term in research literature" (Johnson 1979, p. 7). Much of what was found in the literature about understandings of fear and anxiety can be characterized in one of three ways. Most commonly, fear and anxiety are used as declared or undeclared synonymous, interchangeable concepts (Creighton and Armington 1965; Doerr and Jones 1979; Graham and Conley 1971; Janis 1977; Johnson 1979; Magill 1967). A second type of characterization involves a clear distinction between fear and anxiety (Danesh 1977; Isard 1977). The ambiguity is enlarged with a third treatment of anxiety (neurosis) as being associated with objectless fear, i.e. fear activated in the absence of a discernable object (Isard 1977, pp. 355-384).

All was not totally filled with confusion as the literature seemed in agreement about the similarities shared by "anxiety" and "fear", i.e. the subjective experience of tension as well as activation of the autonomic system. In supporting their study of pre and post operative fear anxiety, Graham and Conley (1971) concluded that the verbal

content of client statements offered the most useful and frequently occurring indicators of preoperative anxiety and fear. Although our data were not analyzed in a way that allows comparison, we would suggest that they might support Graham and Conley. A second widespread agreement in the literature involved most classifications of fear stimuli utilizing two basic origins: (1) innate or natural origins such as sudden noise, heights, sudden loss of support, and pain; and, (2) learning modes, such as classical or operant conditioning or modeling of others.

Although this literature leads to some confusion regarding the definitions of fear and anxiety, some recent discussion among nurses attending the Fourth National Conference on Classification of Nursing Diagnoses suggests some emerging clarity. At that conference the work group recommended definitions for Fear as "a feeling of dread related to an identifiable source which the person validates", and for Anxiety as "a symptom of ineffective coping, knowledge deficits or a precursor to fear. Once the source of anxiety is identified, the problem becomes one of fear" (Kim and Moritz 1982, p. 280).

RELATIONSHIP BETWEEN DIFFERENTIAL DIAGNOSING AND NURSING CARE

Bloch (1980) has stated that

> ...concern about words and definitions is more than semantic. A term's definition goes to the heart of understanding the concept underlying the term. Such understanding and defining is necessary for adequate operationalization of a concept (Bloch 1980, p. 69).

Such clarity of understanding and defining could also have important implications for the quality of nursing care, as consideration of anxiety and fear will show. There is agreement that appropriate nursing care for individuals experiencing fear and for individuals experiencing anxiety differ considerably.

After establishing sufficient interpersonal trust with an anxious client, nursing intervention involves three basic steps (*American Journal of Nursing 1965*). Initially, the client is helped to recognize clues that indicate that he is indeed anxious. From that point, the client can be helped to gain insight into the etiology of his anxiety and to utilize constructive coping strategies to effectively deal with and perhaps master the threat he faces. Effective intervention in regard to anxiety aims at the identification of a specific threat or conflict, which leads to a revision of the earlier diagnosis of anxiety. Anxiety, as such, often seems to be a preliminary nursing diagnostic label, which must lead to the identification of a more precise concern, if effective nursing care

has in fact been provided. Then, intervention proceeds in regard to that newly identified patient problem. From the vantage point of her mental health practice, Weber makes very similar observations:

> Although diagnosis may have been correct given the information the client was able to reveal, continued contact shows "layers" of problems or causes...
>
> As the data base grows and becomes refined and as interventions are evaluated, new diagnoses may be identified and current diagnoses may be changed or verified... (Weber 1979, pp. 534-535).

As Shipley (1977) clearly identified, effective care of the fearful client involves identification of the type of etiological factors. Is the fear a reflexive response perhaps to threatening or unknown sounds, sights or changes in body position? Does it result from Pavlovian conditioning such as a child's fearful response to anyone wearing a white uniform or anyone approaching a bedside? Is operant conditioning more descriptive of the etiological mechanism, as with the individual who regularly obtains a reward from others when exhibiting fear? Or perhaps a vicarious learning experience has occurred via the mass media, observation, or the modeling or others. Knowledge of the etiological mechanism involved offers clues to direct the nurse's intervention with the goal of reducing or extinguishing the fear response, as well as enhancing the client's coping strategies. Use of stimulus exposure to extinguish fear is commonly found in the preparation of the pre-operative clients, and with each exposure, the fear-eliciting properties of the stimulus should be further extinguished (Shipley 1977, p.87). Learning theory is also useful in the positive innoculation of individuals, such as children, for potentially fearful situations, such as hospital environments. Once fear is reduced to a manageable, restricted excitation, the client may be motivated to participate actively in ways to lower the risk of the threat and maximize his resiliency by means of physical exercises, nutritional supplementation, imagery and relaxation, learning of new skills, etc.

IMPLICATIONS

What are some possible explanations for diagnostic confusion between fear and anxiety? We do not know, and the only way to address the phenomenon, we believe, is for studies to be formulated to specifically examine the existence and origins of our findings. Our data suggest that many nurse participants, perhaps unintentionally, downplayed or ignored overt, verbal expressions of fear by clients and did not arrive at a diagnosis of fear. Our data did not provide us with any clues about factors commonly associated with this phenomenon.

It seems likely that more than one factor contributes to the type of diagnostic confusion described here. The literature clearly depicts different directions of thought about fear and anxiety, surely of some influence on the student of nursing. In addition, professional versus lay semantic and conceptual differences may be involved, for example, the familiar and popular usage of "I am anxious" meaning "I am afraid" or "I am impatient" or vice versa. Finally, it is also possible that fear involves a significant societal taboo, similar to those of death and sex, as well as an association as a "negative" emotion.

In conclusion, the findings reported here raise questions about the extent to which nurses validate with the client the data which lead to the nursing diagnoses: what is the level of congruence between the client's and the nurse's perception of the client's human response? Consideration of these findings also suggests that, if nurses are to be assisted to "better utilize knowledge" (Aspinall 1979, p. 185) and to minimize inaccuracies in diagnoses, it is important to delineate the meanings that diagnostic terms have for nurses. This requires repeated observations and testing in clinical practice.

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RÉSUMÉ

Diagnostic de l'infirmier — distinction entre la peur et l'anxiété

Compte tenu de l'importance croissante du diagnostic de l'infirmier dans les soins aux malades, la nécessité de poser un diagnostic précis comme base d'une intervention efficace de la part du personnel infirmier apparaît comme un défi de taille. Dans une phase d'une étude conçue pour découvrir la terminologie utilisée par les infirmiers pour décrire les réactions humaines qui les intéressent (diagnostics des infirmiers), 57 infirmiers posèrent 2 517 diagnostics à la suite de 393 rencontres infirmier-client. Sur ces diagnostics de l'infirmer, 131 faisaient état de peur et 98, d'anxiété ou d'angoisse. La revue et l'analyse de ces cas de peur et d'anxiété, les facteurs jugés contributifs, les données sur lesquelles s'appuyait le diagnostic et le niveau d'accord entre le réviseur et le répondant semblent traduire une certaine confusion au niveau de ces deux concepts chez les infirmiers participants. Ces observations sont exposées à la lumière de la littérature pertinente et soulèvent des questions concernant la démarche diagnostique des infirmiers; elles reflètent par ailleurs la nécessité de définir ces termes avec beaucoup plus de précision par le biais d'études cliniques.