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Panic disorder: is the nurse prepared to identify an attack?

Abstract

This study aimed to identify if nurses are prepared to identify a panic attack. Qualitative, descriptive and exploratory research based on the Theory of Social Representations following the guidelines of the Discourse of the Collective Subject. The sample was made by 15 patients from a general hospital in the city of Jundiaí, state of São Paulo. As the central ideas related to the attacks were raised to identify the panic attack were: "professional experience", "clinical evaluation" and "training." Nurses who are unprepared are linked to core ideas: "lack of professional experience", "specialty" and "faculty approach". Most nurses, due to lack of professional experience, are concerned with detecting a panic attack.

Keywords: Panic disorder, nursing, mental health.

Volume 5 Issue 3 - 2018

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Received: April 19, 2018 | **Published:** May 10, 2018

Introduction

The process of the Psychiatric Reform in Brazil was born by the outbreak of the "health movement" in the early 1970s. In favor of transformation and improvement in the health sector and its sectors.[1] However, the Brazilian psychiatric reform has its own history, inscribed in an international context of changes due to its way of dealing with asylum violence. Its historical process is characterized by complex social politics, involving actor's institutions and forces from different origins.[2] in 1978 the social movement began in favor of psychiatric patients. The Movement of Workers in Mental Health (MWMH) formed by healthy workers and workers, trade unionists, associates of people with a long history of psychiatric hospitalizations.[2] The reorganization of the hospital-centered model was a historical landmark where laws and congresses helped develop proposals for better care for patients with mental disorders, denouncing violence in the asylum and promoting deinstitutionalization in the hospital.[2]

The movement began to expand and in 1987 the first National Conference on Mental Health took place in Rio de Janeiro and in Bauru, São Paulo, and the second National Congress of the Mental Health Workers' Movement (MWMH) in 1989. Bill of Law of the MP Paulo Delgado of the Labor Party of Minas Gerais, Brazil, gives entry to the National Congress that proposes a regulation of the rights to the person with mental disorders and the progressive extinction of the asylums in the country, in view of which the psychiatric patient passes to be treated in the general hospital.[2]

The 1990s were marked by the signing of Brazil in the declaration of Caracas and the holding of the II National Conference on Mental Health, where the first federal norms regulating the implementation of daily care services came into force in the country. Only in 2001, after 12 years that the Law of Paulo Delgado is sanctioned in the country, giving rise to Federal Law 10.216 that extinguishes asylums and regulates the mental patient's situation, aiming at their social reinsertion, consequently the same should be attended in general hospitals.[2] Therefore, all cases involving the care of the mentally ill in emergency situations should be contemplated by hospitals. Among the most common complications, such as panic disorder, psychic disorders affect 3 to 5% of the world population, and have become a serious public health problem, as well as excessive expenses with misdiagnosis of psychic pathology.[3]

Panic disorder is characterized by the nature of its symptoms, different from, for example, the generalized anxiety crisis, which can be confused with other pathologies, since the patient himself reports symptoms related to the lung (hyperventilation, difficulty breathing, feeling of suffocation and asphyxia), heart (palpitations, arrhythmias and tachycardia) and gastrointestinal tract (diarrhea, nausea, vomiting and irritated colon). These complaints can be confused with other diseases and often lead the patient to seek other specialties to be attended to.[4]

The simple expression to describe the panic disorder would be "terror", students arrive suddenly with a panic attack, they arrive suddenly, they last on average 2 to 10 minutes, at least four of the thirteen symptoms: accelerated heart, chest pain, dizziness, nausea, flushing or chills, shortness of breath, tingling, tremor, feeling of unreality, fear of dying, and sweating. To 1.6% of the world population, it was twice as common in women as in men.[5] Panic disorder is among the most frequent diagnoses that lead patients to seek emergency services. Approximately 43% of patients with panic disorder are first seen in a first aid facility.[6]

Nursing professionals as well as all other health professionals should be able to identify the symptoms of panic disorder so that patients can receive the treatment properly. Since 1980 this need has been increasing due mainly to the emergence of specific treatments. The functions of the nurse are focused on the promotion of mental health and nursing actions should be applied respecting the individuality of each case, aiming at social reintegration, disease

control and improvement of the quality of life for the patient and his family.[7]

Methods

The study followed a qualitative exploratory approach. The sample consisted of 15 nurses from a hospital in the city of Jundiai, in the state of São Paulo, in the medical clinic and first aid sectors, which work directly in patient care. The study was carried out after approval by the Research Ethics Committee of the Campo Limpo Paulista School (FACCAMP) registered under No. 2,299,362. The interviews were previously scheduled and performed at the nurses' workplace. The answers were transcribed in full.

The professionals answered three semi structured questionnaires prepared by the researchers, the first one, referring to socio-demographic aspects containing six questions; the second, about the recognition of panic attack containing issues based on the International Classification of Diseases (ICD 10) and Diagnostic Manual and Mental Disorder Statistics (DSM V), and the third with a guiding question: "Do you consider yourself prepared to serve a patient who has a panic attack? Justify." The choice of Collective Subject Discourse (CSD) constituted the method chosen to construct the meanings, allowing the approximation of the phenomenon under study.[8] The CSD consists of the meeting, in a single synthesis speech, of several individual discourses issued as a response to the same research question, by an institutionally equivalent social subject or part of the same organizational culture.

According to the CSD guidelines, three methodological figures were adopted: Key Expressions (KE), Central Ideas (CI) and Collective Subject Discourse (CSD). For the treatment and analysis of data, the order described below was strictly followed. 1st stage: before the beginning of the copy of the data, the answers were read several times to obtain a panoramic idea and a better understanding of the texts. Subsequently, they were copied verbatim, that is, the participants' responses to the Discourse Analysis Tool 1 (DAT1) were copied. In the second stage, the transcribed material was thoroughly read. In the 3rd step all the answers were analyzed to identify the KEs that were passed to italics. Once the KEs were in possession and after reading each one, the CI was identified for each subject of the study, taking care that it represented the description of KE and not their interpretation.

This same procedure was performed with the other responses until the last one. In the 4th stage, the Discourse Analysis Tool 2 (DAT2) was elaborated, containing, separately, each central idea with its respective similar or complementary KEs. In Step 5, the topic of each of the interview questions was grouped together with their respective CIs, as well as the participants, establishing the absolute and relative frequencies of ideas, organizing them into a table. At this point, the DSCs were constructed separately from each IC with their respective KEs.[9]

Results

Of the 15 (100%) nurses interviewed, 12 (80%) are female and three (20%) are male. As for the age group one (6.7%) is between 22 to 26 years, three (20%) are between 27 to 31 years, seven (46.7%) are between 32 and 36 years old whose age concentration of the sample and three (20%) are above 36 years. As for training time in area one (6.7%) is formed up to one year, three (20%) are formed between two to four years, six (40%) are formed between five to seven years and four (26,7%) have been formed for more than eight years. In spite of post-graduation, the participants are divided in several areas: five (33.3%) urgency and emergency, two (13.3%) work nursing, two (13.3%) teaching, two (13.3%) (cardiac intensive care unit), one (6.7%) coronary intensive care unit, one (6.7%) undergraduate degree, one (6.7%) hospital administration and only one (6.7%) did not have any postgraduate course in the area of nursing. With regard to the work sector, five (33.3%) of the emergency room participated, eight (53.3%) of the medical clinic and one (6.7%) were participants. Of the working time in the institution, a large majority (9%) worked for more than eight years, one (6.7%) up to one year, t three (20%) between two and four years and one (6.7%) from five to seven years.

An instrument for the recognition of panic attack (Table 1) based on CID 10 and DSM V was applied, in which they respectively followed their correct answers highlighted in bold. The characteristics that define the panic disorder are: severe anxiety attacks in different situations. Among the symptoms mentioned, those that establish a panic attack are: palpitations and tachycardia; choking sensation; Chest pain; fear to die. A panic attack can last on average: 10 minutes. The disorders that may be associated with panic disorder are: depression and agoraphobia. Jundiai, 2017 n = 15.

The central ideas related to the preparation of nurses in the identification of a panic attack (Table 2) were: professional experience, clinical evaluation and training. The central ideas related to the lack of preparation of the nurses in the identification of a panic attack (Table 3) were: lack of professional experience, specialty, and approach in college. In the following paragraphs the central ideas are presented that point out the preparation of the nurses in the care of a patient in a panic attack followed by the respective discussions:

Table 1 Panic Attack Recognition
What characteristics define panic disorder?

Alternatives	**N**	**%**
Recurrent seizures of severe anxiety in different situations	4	26,7%
Anxiety attacks that occur in specific situations	4	26,7%
Crises of depression occurring in different situations	3	20%
Crises of agoraphobia occurring in specific situations	4	26,7%
There are symptoms for the diagnosis for panic disorder		
Palpitations and tachycardia; choking sensation; Chest pain; fear to die	15	100%
Feeling of unreality; headache; nausea; abdominal pain	0	0
Feeling of suffocation; chills; fear to die; hyperthermia	0	0
Palpitations; feeling of unreality; hyperthermia; Chest pain	0	0
On average how long can a panic attack last?		
5 minutes	1	6,7%
10 minutes	2	13,3%
15 minutes	5	33,3%
About an hour	7	46,7%
What disorders can be associated with panic?		
Obsessive Compulsive Disorder (OCD) and Agoraphobia	2	13,3%
Depression and Agoraphobia	1	6,7%
Agoraphobia and generalized anxiety	9	60%
Depression and generalized anxiety	3	20%

Citation: Dias BVB, Pereira LV, Lima MS, et al. Panic disorder: is the nurse prepared to identify an attack? *Nurse Care Open Acces J.* 2018;5(3):124–127. DOI: 10.15406/ncoaj.2018.05.00132

Table 2 Identification and frequency of the central ideas of nurses who considered themselves prepared to attend a patient in a panic attack. Jundiai, 2017 n = 15

Central idea	Participant	Frequency
professional experience	5, 12, 13	3
Clinical evaluation	3, 5	2
Training	6, 14	2

Table 3 Identification and frequency of the central ideas of the nurses who considered themselves unprepared to attend a patient in a panic attack. Jundiai, 2017 n = 15

Central idea	Participant	Frequency
Lack of professional experience	1, 2, 4, 7, 8, 9, 11	7
Specialty	10, 15	2
Approach in college	1	1

CI: professional experience

Being in agreement with symptoms and medicating according to medical prescription, in an emergency case we will have to start with intravenous or intramuscular medications prescribed by the psychiatrists, or I try to be calm and I hope the crisis passes. If diagnosed with panic attack automatically it is providing a tranquil environment with appropriate specialists such as psychiatrists and psychologists and well-prepared nursing care, nursing prescription, as well as care, diagnosis, and prognosis and maintains comprehensive care. We also have the responsibility of formulating a discharge summary for this agreement because the treatment for this pathology is long term and we also emphasize the importance of the family acting together with the nursing and a preparation after hospitalization, giving continuity to its treatment.

According to Dias[10] professional experience is something fundamental often used as a criterion by companies to minimize expenses with training or updates of employees, in hospitals is no different. The growing demand for contact with psychiatric patients in general hospitals requires the knowledge to attend cases of mental disorders. In this research, professional experience represented (n = 15) 20% of the total number of nurses interviewed who were judged prepared to attend a patient in a panic attack, which shows that the experience can interfere in the preparation, since more than 70% of the sample has time of training in the area of higher nursing for five years, which can reflect in the identification of signs and symptoms as well as the behaviors to be taken before them.

Professional experience in nursing care adds to the nurse's autonomy acting as a therapeutic agent, which promotes improvement in the quality of care practice for the psychiatric patient.[11] Mental health care requires reflection on the part of professionals, who must be prepared to care for these patients, since it becomes a challenge given the need for time, listening, dialogue and especially humanization during care, which are reflected by the experience (11).

CI: clinical evaluation

Yes, I am prepared to attend a patient in a panic attack. Identify the specific needs of each patient in each family. Monitor the signs of anxiety, tachycardia and disorientation and thus welcoming and medicating this patient and if the patient evolves with improvement of the picture after medicating.

According to Stefanelli,[12] in crisis situations care should be immediate focusing on the current problem and aiming for a rapid recovery of the patient's condition. For this, it is necessary the professionals' knowledge for evaluation, taking an initial approach and observing the patient's behavior. In this study the knowledge for evaluation is evident in the instrument used to recognize the panic attack, in which, in the question related to signs and symptoms, all 15 (100%) of the participating nurses answered correctly.

The functions of the nurse should be directed to the promotion of mental health and the assistance to the family and the community. Therefore, there is a need for a reliable interpretation of the patient's state for the planning and implementation of the nursing process, respecting the individuality of each one and stimulating their own participation in their treatment, being the self care.[13]

CI: training

Yes. We are constantly receiving training and retraining.

Permanent education has been used as a tool of the SUS to reorganize the structure of the health system, aiming at the transformation of professional practices based on the needs of the population.[2] It can be individual or collective, with the intention of updating or qualifying the professional with the understanding that the center of the attention provided by the health services becomes indispensable its use in the workers.[14] It was verified that the need to provide training is present, although in n = 15 (100%) of correct answers, the definition of pathology was n = 15 (26.7%) and the duration of the attack was n = 15 (6.7%). In the following paragraphs are presented the central ideas that point out the unpreparedness of the nurses in the care of a patient in a panic attack followed by the respective discussions:

CI: lack of professional experience

I believe I'm not so prepared. In my professional life I never came across this situation, through my medical clinic routine we did not take cases; the admitted patients are transferred to the AP and we do not completely follow these patients, in the hospital there is a sector for these patients. Patient with panic attack I never attended, there is insecurity to deal with psychiatric patients and I did not experience this situation, I do not know how to identify all the signs and symptoms of the patient in the attack.

The reorganization of the hospital-centered model was a landmark in which laws and congresses helped develop proposals for better care for patients with mental disorders.[2] with the creation of the Psychosocial Care Center (CAPS) and decentralization, the contact of health professionals with the psychiatric patient in the hospital environment becomes more difficult, implying lack of experience. In the study, this targeting of the patient to a specific sector may imply in the recognition and the safety of the professional in dealing with an attack, in which six (40%) of the 15 nurses report not having contact with the patient.

Thus, the nurse without specialty and with the little scientific knowledge offered by the graduation cannot assume the commitment with the psychiatric assistance in its different levels of care. He is required to know all the services that make up the care.[15] this is a situation also found in other specialties, because the objective of graduation is to form the generalist nurse. Whatever the area of knowledge, the graduation does not generate professionals fully qualified for all areas of knowledge. This consideration shows that

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future complements and updates are necessary and speaks in favor of integrating knowledge at the undergraduate level.[16]

CI: specialty

It is a specific area of health, which is the mental health and accurate of some specific studies of panic attack cases. Through the psychiatric reform, a new care model for mental health care was necessary, in this context it is necessary the knowledge in a multidisciplinary character. Universities have adapted their contents of undergraduate courses and even of specialization and doctorate in order to discuss current mental health issues, but it is still not enough due to the demand for specialization, so they work with basic training.[17] In the study, this lack of a more specific training can be evidenced in the characterization of the sample, in which none of the 15 participating nurses has a graduate degree in the area of mental health, the lack of specialization is reflected in the expression of two participants, who consider themselves unprepared for attending a patient in a panic attack for lack of specific knowledge about mental health: "It is a specific area of health, which is mental health."

CI: approach in college

No. During the college the subject was little approached.

According to Silvia[18] the teaching and learning process is constantly looking for a new way to improve and improve methodological strategies in order to make better use of teaching. The study carried out showed that the weak approach in the faculty on the subject can influence the preparation of the professionals leading to an unprepared in their formation, impairing their clinical evaluation and their diagnoses in relation to mental health.

Today the discipline of mental health begins to be recognized as indispensable in the training of nursing professionals, who need to learn to use the scientific knowledge that encompasses the comprehension of the human being as a whole, the motivations and behaviors, as well as interact with the patient in the critical moment of suffering.[19] With this analogy, the teaching of nursing care in mental health comes with a curricular change that has encountered difficulties in including mental health in the integrality of health actions, but at the same time tries to maintain the specificity and the formation of the generalist nurse. Because it is something new, we see a distancing and a difficulty between what is taught in university education and what is practiced in basic health units, in relation to nursing care in mental health.[19]

Conclusion

Nurses who reported being prepared to identify a panic attack are anchored in their day-to-day work experience that may be related to length of service, since most participants have worked at the institution for more than 8 years, clinical evaluation of the signs and symptoms, in which all the participants correctly answered the question about signs and symptoms of a panic attack and also by constant training that the institution offers.

Most of the participating nurses consider themselves unprepared to identify a panic attack; the difficulties encountered are related to the lack of professional experience because they do not have frequent contact with the patient, the superficial approach of the topic in nursing graduation, and the lack of specificity in the area, since none of the participants have postgraduate degrees in the area of mental health. Although the institution offers constant training most nurses do not consider themselves prepared to identify a panic attack.

Acknowledgments

None.

Conflict of interest

The author declares that there is no conflict of interest.

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Citation: Dias BVB, Pereira LV, Lima MS, et al. Panic disorder: is the nurse prepared to identify an attack? *Nurse Care Open Acces J.* 2018;5(3):124–127. DOI: 10.15406/ncoaj.2018.05.00132