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Anxiety and Anxiety management By  
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ABSTRACT  
Anxiety is a common problem in patients with mechanical ventilation. Anxiety is also difficult to assess, because patients cannot talk, sensation of dyspnea, immobility, and some of the patients is running low of consciousness. Anxiety in patients with mechanical ventilated patients can impact the physiological responses and psychological responses. Anxiety can increase the sympathetic nervous system, influence the regulation system of body vital sign, fear, and feeling lonely. Nurse need to know the anxiety perspective, and anxiety assessment to give the accuracy nursing intervention. Keywords: Anxiety, Assessment of Anxiety. Mechanical Ventilated patients  
1. BACKGROUND AND SIGNIFICANCE OF THE PROBLEM  
Mechanical ventilation is a life-saving treatment for patients with respiratory failure. Although ventilator support saves lives, it can also cause many negative physiological and psychological impacts on patients. Such physiological impacts include breathlessness, sleeplessness, immobility, restlessness, inability to talk, and the need for frequent suctioning. Anxiety is the most common psychological impact that ventilator support has on patients (Chlan, 2003; Seaward, 2002). Anxiety increases sympathetic nervous system stimulation, breathing difficulty, oxygen demand, and myocardial stimulation, all of which contribute to high levels of anxiety (Chlan, 1998). Patients using mechanically-ventilated support systems often experience adverse events due to this anxiety, such as constriction of arteries and airways in the lungs (Mark B. Yagan, Wite, & Sraob, 2002).  
2. ANXIETY IN MECHANICAL VENTILATED PATIENTS  
Theories and Definition of Anxiety  
There are three main theories that explain the theory of anxiety: behavioral theory, and biological theory causes of anxiety. These theories are psychoanalysis (Sadock & Sadock, 2003). The theories explain that anxiety comes from exposure to external unsympathetic energy. People then seek to take advantage of the anxiety response in penetrating the conflict rather than accepting it. As a result, anxiety affects normal physical and mental conditions and this leads to behavioral and emotional abnormalities.  
1. O MALAYSIAN JOURNAL OF NURSING OCTOBER 2010. Psychoanalytical Theory of the perception of risk from the unconscious status Sigmund Freud explained that anxiety is a sign (Sadock & Sadock, 2003). This, according to the theory, owes to the psychological conflict of unconscious sexual or aggressive desires and the threat of superego or external reality. The signs of anxiety emerge from the ego's using psychological protective mechanisms to prevent undesired thinking or feeling, which is expressed as consciousness. Anxiety may derive from an individual perception. A person believes that he or she is in danger of an external harsh force and seeks to exploit the anxiety response by penetrating the conflict rather than ignoring it.  
2. Behavioral Theory  
Behavioral theory states that the

response of a person to anxiety depends on a particular stimulus. This theory proposes that anxiety comes from an assessment of the environment, where conditions are deemed to affect the normal physical and mental condition and be unsafe and violent beyond what one can tolerate. It thus leads to behavioral and emotional abnormalities. Existentially, this theory explains that anxiety occurs because the person regards life as meaningless and suffers from having to live with this perception of reality. Hence, the person suffers from anxiety.

3. Biological Theory Biological theory was developed from clinical studies on experimental animals suffering from induced anxiety. This theory states that biological changes cause anxiety, or that anxiety causes biological changes. It emphasizes individual responses and sensitivity to biological responses. The term "anxiety" comes from the Greek word *agon*, and is derived from the modern words anguish and agony. In German, *agon* is used for describing painful feelings of terror and dread (Grimm, 1997; Hooi, 2000). In Latin, *agon* has a similar meaning: narrow or shrunken and causing discomfort. The definition also includes a feeling of restlessness and worry towards uncertain situations. Sometimes it refers to fear of consequences. People feel impatient, oppressed, fearful, and/or frightened about the unknown, and possibly uncertain or unsure about the future (Glas, 2001). Anxiety is defined as a subjective experience of apprehension or tension, imposed by the expectation of danger or distress, necessitating the need for special (1950) in his classic paper, examined the problems action (Kelty, 1950). Sir Aubrey Lewis as cited in Kelly presented by the word anxiety, as used in psychiatry is discussed the usage of the word and its derivations and listed the characteristics of anxiety in the following categories:

1. It is an emotional state involving subjectively experienced qualities of fear or similar emotions
2. The emotion is unpleasant. It may be a feeling (terror, alarm, fright, panic, dread), of impending death or collapse. It is directed towards the future.
3. There are subjective bodily discomforts during the period of the anxiety: a sense of constriction in the chest, tightness in the throat, difficulty in breathing, and weakness in the legs. There are several bodily disturbances which manifest during anxiety. Some of these are of functions normally under voluntary control, such as agitation, propensity to scream, and sudden defecation. Others are not under voluntary control, including dryness of the mouth, excessive sweating, tremors, the need to vomit, palpitations, and other physiological and biochemical that can be detected with appropriate methods of investigation. The American Psychiatric Association (2000) defines anxiety as a response to life events, feelings of uncertainty, uneasiness, apprehension, or tension that a situation, or danger, the source of which is largely person experiences in response to an unknown object, unrecognized. Furthermore, Spielberger and colleagues (1983) separate anxiety into state anxiety and trait anxiety. State anxiety is defined as an unpleasant, and heightened autonomic activation of the emotion characterized by subjective feelings of tension, nervousness, and worry. State anxiety is often transitory and it (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, can fluctuate and recur when appropriate stimuli evoke it (1983). a general tendency to perceive and respond to threats in people with both state and trait anxiety exhibit to environment. When a person is faced with stressful situations, trait anxiety causes him or her to perceive them as dangerous and threatening, and the person responds to them with an intense elevation of state anxiety. It endures over time and tends to be relatively the more probable the individual will experience more stable and predictable. The stronger the trait anxiety, intense and more frequent elevations of state anxiety in the threatening situation. Several studies (Chlan, 1998; 2003; Chlan, Jaison, 2002; Mok & Wong, 2003) also defined anxiety as a state of tension, apprehension, nervousness, and worry, and as an emotional state involving subjective feelings of these feelings to be associated with the sympathetic nervous arousal system. The physical manifestations of anxiety involve extreme shifts in body temperature, urinary urgency, mouth dryness, pupil dilation, appetite loss, and diaphoresis. Thus, anxiety is the emotion and feeling that occurs when an individual faces a stressful, unsafe, dangerous, and insecure. She or he will take situation. The individual will assess the situation as danger. This assessment depends on individual beliefs, steps to protect herself or himself from the perceived thinking processes, perceptions, and past experiences. Once a person falls into this situation, she or he will respond physically (shaking, sweating, etc.), mentally (irritability, aggression, restlessness, etc.) and socially (fretfulness, stupefaction, etc.)

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adrenalin. There are three important facts that cause anxiety reactions increase the secretion of the sympathetic nervous system, 2) many physiological changes to increase: 1) the adrenal medulla is linked to changes are known to complement emotional arousal (e.g., tachycardia, pupil dilatation, and signs of increased sympathetic nervous system activity), and 3) the adrenal medulla Anxiety and Anxiety Assessment outcomes in Mechanically Ventilated patients: concepts Analysis glands share in widespread subjugation of the viscera to sympathetic control (Kelly, 1980). Anxiety is correlated with adrenaline and noradrenaline excretion. A significant correlation between anxiety and adrenaline, and between aggressiveness types of psychiatric and medical patients (Cohen et al., and noradrenaline excretion, has been found in various Silverman et al., cited in Kelly, 1980). In addition, response to the intensity of the psychological stimulus anxiety can increase catecholamine production in adrenal gland produces nearly all of the adrenaline in (Euler as cited in Kelly, 1950). The medulla of the body, excluding only some of the noradrenaline and venous blood, leaving it catecholamine. The proportion between them is 80% adrenaline and 20% noradrenaline (Selye, 1980). Adrenaline has both alpha and beta systolic blood pressure, while diastolic blood pressure effects and causes an increase in heart rate and rise in is unaltered or may even fall. Noradrenaline consists of almost pure alpha activity and causes a decrease in pressure, due to constriction in the arterioles (Guyton, heart rate and rise in both systolic and diastolic blood 1991; Kelly, 1980). Moreover, anxiety can produce hyperventilation, rhythms, and a sensation of breathlessness. Patients involving

shallow breathing, disorganized respiratory reporting shocking sensations and other breathing problems during anxiety are a common clinical researchers regarding a possible link between the experience. There has been sustained interest among malfunction of the respiratory system and anxiety (Griez & Perna, 2003).

### CAUSES OF ANXIETY IN MECHANICAL VENTILATED PATIENTS

mechanical ventilated patients. A common cause of Anxiety is a common phenomenon in anxiety in mechanical ventilated patients is the sense Rotondi and colleagues (2002) studied 150 patients of a communication barrier (Atasad & Ahmod, 2004). who received ventilator support for more than 48 hours. The researchers found that many of the patients did not remember the experience, but for those who did, they recalled that they were thirsty, felt tense and out report that the causes of anxiety in mechanical ventilated lonely, and experienced nightmares. Existing, of control, had difficulty swallowing and speaking, felt patients consist of three stressors. They are as follows: (1) psychological stressors, (2) treatment stressors. and (3) environmental stressors. Psychological Stressors

Recently, some studies described varied stressors that manifest in mechanical ventilated feelings of bewilderment, loneliness, and high level patients. These included sleep deprivation, nightmares, panic. In addition, patients also reported submission to of fear and anxiety that bring on attacks of terror and caregivers, relatives' distress, depersonalization, and insecurity as factors leading to anxiety, and even agony (Lusk & Losh, 2005; Rotondi et al., 2002). unable to communicate verbally. They often reported Obviously, in mechanical ventilated patients are that they experienced psychological distress during breathlessness, frequent suctioning, inability to talk, treatment, including anxiety and fear. The sensation of uncertainty regarding surroundings, isolation from of anxiety (Bunt as cited in Chlan & Tracy, 1999; Dileo, others, and general fear contributed to their high levels Brodt, & Grocke, 2008; McKinley, Stein-parbury, & Chehelabi, 2004). Dependence on ventilator support to which can result in sleep disturbance, increased breathe and the inability to speak can bring on anxiety, sympathetic output. Increased sympathetic output can myocardial oxygen consumption, and increased it makes the process of weaning a patient off ventilator lead to tachypnea, tachycardia, and hypertension, and using equipment more difficult. The patients, to meet their needs (Lindgren & Ames, 2005). They inability to speak may also make it harder for nurses may have co-existing disorientation or suffer from drug Furthermore, the physical manifestations of many effects, which make clear communication difficult lack of information, depersonalized, care, and lack of disease states can mimic anxious behavior. In addition, sleep and rest were associated with fear, anxiety, and vulnerability. Treatment Stressors unable to express their needs, or even synchronize In Mechanical Ventilated patients are often their own breathing (Lusk & Lash, 2005). Tubes in the mouth or nose have been frequently cited as one of the strongest causes of anxiety, followed by the immobility highly regarded by these patients include suctioning, caused by tube placement. Other treatment stressors include thirst (Van de Leur, Zwaveling, Loef, Vin de Schans, 2003). Pain, inability to sleep, the presence of tubes in the nose or mouth, lack of self-control, and the presence of restraints were the top five treatment factors.

### LEVEL OF ANXIETY IN MECHANICAL VENTILATED PATIENTS

Analysis of stressors in patients (Lusk & Lash, 2005). When in mechanical ventilated patients suffer anxiety, the levels usually range from moderate to severe Environmental Stressors (Chlan, 2003; Wong et al., 2001). Wong and colleagues Environmental stressors encompass unfamiliar used music as an intervention in a study on mechanically surroundings and people in an intensive care unit, the ventilated patients with primarily respiratory medical constant activity in such a unit, and also the multitude of diagnoses. Each day, the patients listened, in random order: other bothersome sights and sensations that are usually order, to 30 continuous minutes of music, and were then present. For example, stressors might include odd provided 30 uninterrupted minutes of rest as a control. ) machinery with repetitious droning, disturbing atmospheres, The Chinese version of Spielberger's State-Trait Anxiety Inventory (STAI) 1 loud noises, unpleasant odors, unpleasant sights and sounds, and continuous bright light, causing interruption after each intervention. Assessed physiologic variables of the circadian rhythm (Bennum, 2001; Lusk & Lash, included mean blood pressure and respiratory rates. 2005). Other investigators documented that anxiety was The reported results of the study included a significant decrease in anxiety caused by hearing nearby caregivers talk and laugh with decrease in STAI scores after both interventions. seemingly no concern for the patient (Jastremski, 2000). However, music, with a reported mean STAI score of 1.5 (Thomas, 2003). However, problems caused by noise, difference of 14 points, was more effective than the unpleasant sounds, and machinery atmospheres might be control intervention of rest, with a reported 3.84 point unavoidable in many ICUs. mean STAI score difference. Although the physiologic variables of respiratory rate and mean blood pressure significantly decreased after both interventions, the results were not clinically significant. Overall, music of The degree and duration of anxiety in may have a calming effect on mechanically ventilated ) mechanical ventilated patients, as demonstrated by patients and may assist in decreasing stressors. It is each individual, varies depending on the individual's specific situation and personal characteristics (Moser et al., 2003; Sungkhaw, 2001). Anxiety is categorized into is classified in terms of state and trait anxiety. State Anxiety in mechanical ventilated patients in four levels of intensity: mild anxiety, moderate anxiety, anxiety is conceptualized as a transitory emotional distress severe anxiety and panic anxiety (Shives, 2005). state condition of the human organism that is 1. Mild anxiety is associated with the tension of characterized by subjective. It causes feelings of tension day-to-day living. During this stage the patient is and apprehension, and results in the activation of the 5 alert and his or her perceptual field is increased. autonomic nervous system. State anxiety may vary in intensity - He or she can see, hear, and grasp more than intensity and fluctuate

over time. Trait anxiety refers to a relatively stable individual differences in anxiety. It is the difference between people with relatively stable individual differences in anxiety. Trait anxiety, a person focuses only on immediate concerns. The person blocks out or threatens and those who respond to such situations in selected areas but can continue to problem solve. with elevations in the intensity of their state anxiety. Some symptoms, such as headaches, strong reactions (Spielberger et al., 1983), breathing, and eating disorders are present due to the anxiety. State anxiety in mechanically ventilated patients. In severe anxiety, a patient experiences significant reflections of their environment over shorter periods of time and a reduction in the perceptual field, disorientation, from situation to situation. State anxiety may be caused by a lack of awareness of the environment, and inability by the environment of an intensive care unit, with its focus on what is really happening. A patient highly technological machines and monitoring devices will feel physically and psychologically uneasy (M.B. Yagan, White, & Staob, 2000). Therefore, such patients will make attempts to reduce anxiety. patients may feel higher anxiety compared to patients. In panic anxiety, a person suffers loss of control, not on ventilator support. In contrast, trait anxiety is unable to do things with any sort of purpose. mechanically ventilated patients is individual-based. and? There is increased motor activity, decreased ability is not dependent on specific behaviors to or responses to relate to others, and distorted perceptions. The in specific situations. In the ventilator support person is in a state of panic, and is unable to patients will probably feel some anxiety regardless of- It communicate or function effectively. other conditions.

30 OBEQ 2]: MALAYSIAN JOURNAL OF NURSING 13 Anxiety and Anxiety Assessment outcomes in Mechanically ventilated patients: concepts Analysis Anxiety in mechanically ventilated patients by responses to some threats related to the particular generally is considered to be state anxiety. It is caused manifest anxiety with feelings of tenseness and condition and treatment of the patient. Those patients nervousness, and with restlessness or agitation. The medical conditions and the environment may result in complexity of patients' illnesses in relation to their diverse expressions of anxiety. Similarly, Moser and colleagues (2003), in their study of anxiety assessment and management in critical care nursing, found that the physical manifestations of many disease states can mimic anxiety behaviors. INFLUENCING FACTORS ON ANXIETY LEVEL IN MECHANICALLY VENTILATED PATIENTS to anxiety in Mechanically Ventilating patients. The There are a number of factors that contribute results of some studies showed that factors contributing to anxiety mechanically ventilated patients include physical discomfort, unfamiliar environments, altered uncertain outcomes. The degree of anxiety level communication patterns, unfamiliar procedures, and exhibited by in Mechanically Ventilating patients can length of time on ventilator support, and biological depend on gender, age, need for ventilator support, factors. Sex Sex has been revealed to have a connection with anxiety in several studies. Mitchell (2003) stated that anxiety was higher in female patients and novice patients. Female and novice patients were observed to experience greater anxiety than male patients, although they did not show significantly different levels. Obviously, gender cannot be changed. Women are somewhat more open emotionally than men. Even among women who face highly stressful situations in their lives, the risk of heart disease research on psychological factors in heart disease disease remains considerably lower than men. The bulk has focused on men rather than women. Therefore, their physiological reactions to anxiety tend to be less intense (Kelly, 1980). ventilated patients, Chlan (2003) found that the mean In a different study on sex and anxiety in mechanically ventilated patients, the mean anxiety level was 78.7 for women and 48.7 for men. (hSeDm: ea11n.4s) tawethanaxriaentygesicnorsetaitne s: ta1te3.a2n) xwiewtyh sacorraengaemoonfgstfa-etmeaalnpxieattiyenintsvevwnatso4ry9.s6co(SreDs anxiety inventory scores from 24 to 79. This indicates 14 MALAYSIAN JOURNAL OF NURSING OCTOBER 2010 rmesauleltepdatiinemtso.dTehrautse, abnaxsieedyoanmtohnisg bstoutdhr-1.i-: .: =- \_: "-: that the experience of receiving ventilator support is assumed that sex is not likely directly related, in mechanically ventilated patients. Age management of anxiety in patients. Anxiety, age differences have a profound effect: Among the causes of anxiety are fear of death, frequently experienced in children and elderly. r: I illness, anxiety: chronic illness, and, ultimately, death rB; - \_ ainsd alosssociafftferidenwdsithanadghitoamtioe.nI, neealrd1elrj.r\*;; - : - Zimmerman, & I{ieyeen, I 995).

22pa00an00txi4ei8e)n;t.ytMsTinhScbienKouMmitrneeelasecelsyhat,ouardcnSihineitceesarmishIV-iafdPeovdaenulretnsibl-dahuaotrgaeywend,ndxPCietaphhtaaieythhinienaetngsinentsoa.ctb(apoiDn.enintrh,jrt-,\_,\_\_.I"-jj-: . . , \* = in females between 30 to 59 years of age u'ho r;; ' - \_ ventilator support. They also found that elderly patients have higher anxiety scores than younger patients in intensive care who are receiving ventilator support. Indication of Using Ventilator Support respiratory support. It is used in patients with respiratory failure. Ventilator support is a common method for critical care. There are indications that respiratory failure or those who require respiratory support. studied descriptions of anxiety levels by ventilator support for patients creates state anxiety. In 2001, f . . individual differences (n = 200) and found that . . porrosbpleinmasl s(unr:g3elroy/o(l3,om/oe,amneaannxiaentyxie:ty5:0.54)6,.&7b\.\dCrr:\-a:, primary medical diagnosis categories were respiratory, transplantation (n = 13.5%, mean anxiety: 78 r, or valve repair surgery (n = 41%, mean anxiety: 74.5), and other (n = 49.5). The results indicated that patients with "other" medical diagnoses (n = 22%, mean anxiety: 78.7) were primarily for respiratory problems on ventilator support (e.g., surgery, sepsis, myocardial infarction, congestive heart failure, etc.) = Another group of investigators studied patients with chronic obstructive pulmonary disease, who used ventilator support and who often experience dyspnea and anxiety. The [experimental](#)

group received [daily acupuncture therapy and massage](#) treatment, [10 days](#). Patients in the [comparison group](#) received [mechanical ventilation had high levels of perceived between groups at the baseline \(t : 0.61, p : 0.54\)](#). In the anxiety. There was no statistically significant difference experimental group, anxiety levels gradually decreased from day 2 until day 72, but then gradually increased during the follow-up period (Shiow-Luan, Juei-Chin, Kuan-Chia, & Ue-Lin, 2005). Patients' apprehension about their underlying health problems can also influence anxiety levels. [Factors that may contribute to one's need for ventilator support usually involve major diseases of the respiratory tract, such as pneumonia, chronic obstructive pulmonary disease, and lung cancer](#) (Chlan, 2003). Furthermore, the physical manifestation of many disease states can mimic anxiety behaviors. Given these circumstances, it is potentially exacerbating pathological conditions and increasing the complexity of patient care. The underlying disease, hospitalization, and alteration in circadian rhythms can easily disrupt the lives of in Mechanical Ventilated Patients. Circadian rhythm refers to the biological cycles which last about 24 hours, or one day. Depending on the underlying disease, a patient's circadian rhythms can change (Hartshorn, Lamborn, & Noll, 1993). [The Circadian Cycle is controlled by a region of the brain known as the hypothalamus, which is the master centre for integrating rhythmic information and establishing sleep patterns. Within the Circadian \(24-hour\) Cycle, a person usually sleeps approximately 8 hours and is awake 16 hours. During the wakeful hours, mental and physical functions are most active and tissue cell growth increases. During sleep, voluntary muscle activities nearly disappear and there is a decrease in metabolic rate, respiration, heart rate, body temperature, and blood pressure. The activity of the digestive system increases during the resting period, but that of the urinary system decreases. Hormones secreted by the body, such as the stimulant epinephrine \(adrenaline\), are released in maximal amounts about two hours before awakening so that the body is prepared for activity](#) (Paul & Lemmer, 2007). It may be that in Mechanical Ventilated Patients manifest anxiety in widely diverse ways (Moser et al., 2003). Sleep in mechanical ventilated patients is greatly interrupted. Such patients have been noted Lengths of Ventilator Support receive ventilatory support, they generally report. Regardless of the lengths of time patients to awaken frequently, have little to no REM (rapid eye movement) sleep, sleep for shorter periods, and rate their quality of sleep as poor (Nancy, 2000). The experiencing moderate anxiety, even after just six days impact of sleep disruption in in Mechanical Ventilated (Chlan, 2003), indicating that anxiety control requires Patients is not fully known (Horton, 2005). However, continuous nursing attention regardless of the length of sleep inadequacy will impact physiological readiness time a patient is on ventilator support. Chlan categorized for weaning off ventilator support (Hampton, Griffith, the lengths of ventilator support treatment in that study & Howard, 2005). Therefore, further study of sleep as follows: [less than 5 days, 6 to 21 days, 22 or more](#) deprivation is needed. [days, and chronic \(receiving ventilation in place of residence before hospitalization\)](#). Chlan, then, reported that patients receiving ventilator support for 22 ASSESSMENT OF ANXIETY OUTCOMES or more days had to have the highest levels of anxiety. State-Trait Anxiety Inventory (S TAI) [However, there is, in general, wide variability in the length of ventilator support](#) time. Thus, higher levels The STAI was first developed by C.D. Spielberger and R.L. Gorsuch in 1964 to assess the state of anxiety may be attributed to other factors, such as trait anxiety of college students (Spielberger et al., illness severity or weaning difficulty related to severe 1983). Since then, it has been revised and validated. dyspnea. This requires further investigation. and has been extensively used in research and clinical Biological Factors Patient responses to anxiety experiences during illness may have deleterious effects on the patients, practice for different age groups in different cultures. STAI is a self-evaluation questionnaire. composed of two separate self-reporting scales: (1) State-Trait Anxiety Inventory (SAI). and (2) Trait-Anxiety Inventory (TAI) Anxiety and Anxiety Assessment outcomes in Mechanical Ventilated Patients: concepts Analysis The SAI Scale is used to evaluate anxiety experienced developed with 200 pregnant women and used item- at a particular time, and it reflects a transitory emotional reminder correlations to create a scale composed of six SAI response to a stressful situation. In contrast, the TAI emotional items (calm, tense, upset, relaxed, content, evaluates anxiety experienced in general, and reflects worried) that had the highest correlations (0.53 - 0.71). a stable predisposition to anxiety as determined by However, when it was used in mechanical ventilated personality patterns (Spielberger et al., 1983). patients, the specific items of this STAI were puzzling to them, leading to uncertainty as to how to respond to the The STAI has been well documented for items. For example, "I feel content" was intended to be its validity and reliability. Its construct validity was an anxiety-absent item. Many ventilator support patients examined by Spielberger using 197 high school students had difficulty with this item, resulting in confusion about in four different situations: nonnal, relaxed, exam- the meaning of the item and uncertainty about how they related, and stressful. The mean scores of the exam- should respond to it (Chlan, 2003). The 6-item version related situation were reported as statistically higher of the SAI was used to measure anxiety level changes in than the other situations, indicating a high validity mechanically ventilated Chinese patients during music (Spielberger et al., 1983). The internal consistency intervention studies. The internal

consistency coefficient estimates for the State-Anxiety Scale range from 0.83 to 0.92, and those of the Trait-Anxiety Scale range from 0.86 to 0.92. The test-retest reliability coefficients for Trait-Anxiety were high (0.73 to 0.86), while those of the Visual Analogue Scale (VAS) for State-Anxiety were low (0.16 to 0.54). According to Spielberger and colleagues, the low reliability from the test-retest was expected to measure assessments of phenomena, such as anxiety, pain, and mood states. It was used to measure many types of subjective changes, such as anxiety which results from situational stress. The analogue scale consists of a 1-100 mm line drawn on a paper with STAI is widely used in some research for in negative and positive statements about anxiety. The left end of the scale indicates no anxiety or zero anxiety, and the right end indicates the highest level of anxiety. The patients of Mechanical Ventilated Patients already done (Chlan et al. 2003) were asked to show how much anxiety they felt by marking the analogue scale (Redman, Nahas, & Molassiotis, 2001). One study (Chlan et al., 2007; Mok & Wong, 2003; Sungkhaw, 2001; Wong, 2003) developed a shortened State Anxiety Scale from the The VAS can be used to measure anxiety levels of patients receiving mechanical ventilation. However, Chlan et al. (1993) and Savik, and Weinert (2003) explained that, although Wong, Lopez-Nahas, and Molassiotis (2001) have used VAS is easy and quick to use on ventilated patients, a shortened Spielberger state anxiety scale to measure the VAS has measurement limitations. Elderly patients anxiety in mechanical ventilated patients. In both may have difficulty conceptualizing the abstract nature of the VAS, which brings into question the validity of holding up cards in response to questions. The internal validity of those responses (Raisner as cited in Chlan et al., 2003). consistency coefficient estimates were 0.67 and 0.72. Moreover, the single item format of the VAS precludes respectively, which are less than the 0.82 originally rigorous psychometric testing to determine the reliability reported for the 6-item Spielberger scale (McKinley, and validity of the instrument, resulting in a less precise Stein-Parbury, Chehelabi, et al., 2004). Although this measurement of anxiety (L'ormman & Streiner 1994, as brief scale was minimally difficult for in mechanical ventilation patients, Chlan (2003) remained concerned about its validity for this population and recommended further work to develop an anxiety measurement suitable for Mechanical Ventilated Patients. The Anxiety Status Inventory was developed by Zung William in 1971 (Grimm, 1997). It consists of Anxiety Status Inventory (SAI) was first developed by Marteau a shortened 6-item version of the State Anxiety Scale. The first is the ASI, which is a 20-item rating scale. It evaluates the severity of anxiety symptoms on and Bekker (1992). This shortened SAI was initially a 4-point rating scale, ranging from one, which means no anxiety, to four, which indicates severe anxiety. The second part is a self-rating anxiety scale, which is a 20-item self-reporting scale. mechanical ventilated patients. Because anxiety is a common phenomenon in the ICU, the ASI consists of positive and negative statements that ask respondents if they have experienced the help they need. A patient may become anxious if he or she has experienced the help they need within the last week. A "1" rating means little or no anxiety; a "2" rating means moderate anxiety; a "3" rating means severe anxiety; a "4" rating means extreme anxiety. The reliability of the ASI in the study was 0.66. The concurrent validity correlations with the Taylor Manifest Anxiety Scale were 0.33 for ASI and 0.30 for the self-rating anxiety scale. To determine if a patient's subjective responses to the ASI (what he's feeling) and his objective responses to the ASI (what you observe) are related, we used a Pearson correlation coefficient. The results showed a significant correlation (p < 0.05). We gratefully acknowledge the Director of the Ministry of Higher Education of the Indonesian Government for giving full financial support to support the completion of this manuscript.

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