

UNIVERSITY HONORS PROGRAM

SENIOR PROJECT - APPROVAL

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PROJECT TITLE: The Effects of Preoperative Education on the
Reduction of Pre-anesthesia Anxiety

I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

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The Effects of Preoperative Education on the Reduction of Pre-anesthesia Anxiety

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Abstract

This project examines the possible anxiolytic effects of preoperative education concerning the anesthesia process in presurgical patients. While surgery patients are given significant education about the nature of their surgical procedure, the anesthesia process is often explained with much less detail. This study is designed to show a correlation between pre-anesthesia education and reduction of presurgical anxiety. Twenty-three patients (11 control and 12 experimental) were selected from the day surgery schedule at Fort Sanders Parkwest Hospital. Day surgery patients were selected in order to minimize the amount of anxiety felt towards the surgery itself, as all outpatient surgeries can be considered somewhat "routine" in nature and relative risk. Patients were both male and female between the ages of 30 and 59 with an average age of 48. Data collected from all patients included heart rate, blood pressure and respiratory rate, recorded in the patient's room in day surgery, in pre-surgical assessment (PSA) and upon returning to the room in day surgery. Additionally, patients completed two anxiety questionnaires, the Penn State Worry Questionnaire (PSWQ) and the Beck Anxiety Inventory (BAI). Results were determined by comparing these values between groups, as well as by comparing the average postoperative hospital stays of patients in both groups. Patients in the experimental group had significantly lower diastolic blood pressures in PSA than the control group ($\alpha < .025$). Differences in heart rate and postoperative stay approached significance as well.

While the data examined did provide some significant findings, the small sample size requires that these data be interpreted as a pilot study at best. Other methodological constraints and considerations are addressed here as well, such as the patient's perceived locus of control and support system. However, given the increased prevalence of outpatient surgeries, this study supports the relevance of preoperative teaching in reduction of anxiety in the day surgery patient. This study does, however, indicate the need for further examination of the effects of education on reduction of presurgical anxiety.

Introduction and Review of Literature

Surgery can be one of the most frightening experiences a person faces. Pre-surgical anxiety can be a significant complication of this experience. Surgery itself is often a greater source of fear or anxiety than the condition it is intended to correct. One approach to minimize pre-operative anxiety is providing surgical patients with education as to the nature and rationale for their surgery. However, of the aspects of surgery patients are anxious about, the most frightening is often the anesthesia. Whereas patients are receiving increasing amounts of information about their surgery, generally they are not as informed of the precise procedure of the anesthesia. Apparently, patients fear the loss of control associated with general anesthesia. Other pre-anesthesia fears may include waking during surgery, not waking at all, or personal “embarrassment” resulting from uninhibited speech or actions. The fear of revealing all sorts of secrets or personal information is very common even though this does not occur (Blacher 1987). Blacher has suggested that surgeons “would worry about a patient who is not anxious preoperatively, yet we can question this, since we know that patients who are not anxious require less anesthetic agent and seem to face the ordeal with greater equanimity and therefore a better physiological situation”(1987). Therefore, it would appear that any effective method of reducing the amount of fear or anxiety toward surgical anesthesia would be of benefit to the patient. Often, patients are reluctant to

express their fears to the surgeon or the anesthesiologist for several reasons. The patient may fear the perceived negative effects of questioning the knowledge and expertise of the physician, appearing ignorant or foolish in the eyes of those whom he wants to respect and thus take care of him, or being thought strange or even slightly insane by expressing his concerns (Blacher 1987).

The pre-surgical patient undergoing anesthesia faces an apparent paradox. He looks to anesthesia to provide pain prevention and/or oblivion, but he also fears the loss of control experience of putting his life in the hands of a complete stranger who will indeed have the power of life or death over him (Blacher 1987). The term *psychologically informed intervention* has been used to describe a wide range of activities performed by all different kinds of health personnel intending to lend emotional support to pre-surgical patients (Schlesinger *et al* 1980). Studies have shown that patients who received some sort of psychologically informed intervention preoperatively were less anxious about their surgery and therefore not only did they face the surgery with a calmer demeanor, but also had more successful outcomes in terms of postoperative hospital stay. Several examples of these studies involving psychologically informed intervention are provided in Table 1.

Table 1. Examples of psychologically informed intervention

Before surgery, patients were given instruction from a nurse regarding what to expect during and immediately after surgery (Archuleta <i>et al</i> 1977).
Children ages 4-12 facing ENT, general or urinary surgery were shown a film designed to educate them about what to expect and to present non-frightened responses (Melamed and Siegel 1975).
Children of average age seven were given psychological preparation by the same person at six different times during the preoperative hospital stay (Wolfer and Visintainer 1975).
Adults preparing to undergo orthopedic surgery listened to recorded hypnotherapy for 20 minutes (Field 1974).
Adults facing cardiovascular surgery received one or more psychiatric interviews intended to provide information and education, as well as emotional support (Surman <i>et al</i> 1974).
Adult males facing hernia repair surgery listened to a tape recording providing information about what they could expect. They listened to the tape on two occasions two days prior to surgery (Vernon and Bigelow 1974).

Of these varying approaches to alleviation of preoperative anxiety, one of the most commonly used methods of psychological preparation is provision of both procedural and behavioral information (Johnston and Vogele 1993, Mitchell 1994, Augustin and Hains 1996). A meta-analysis of 68 studies supported the idea that preoperative patient education provides beneficial effects, both by promoting favorable surgical outcomes and by reducing experienced anxiety (Augustin and Hains 1996).

Currently, increasing numbers of surgeries are being performed on an outpatient or day surgery basis. With cost existing as an ever present factor in health care, this has served as a benefit to both patients and hospitals.

Improvements in surgery and pharmacology have helped to achieve this growth in prevalence of same-day surgery. Improved surgical techniques and anaesthetic agents, i.e., less invasive surgery and enhanced drug treatment, have been considerable factors in allowing once time-consuming procedures to become far quicker (Hodge 1994, Jarrett 1995). With this increase in same-day surgeries has come an increased awareness of the psychological needs of the day surgery patient. Several recent studies have been performed to evaluate various techniques of identifying and potentially reducing preoperative anxiety in day surgery patients (Gaberson 1995, Augustin and Hains 1996, Shafer *et al.* 1996, Mitchell 1997). These studies have focused on alleviating the patient's overall anxiety, whether it is due to the nature of their condition, the impending surgical procedure, the process of general anesthesia, or any combination of these. Because same day surgery is becoming so common and the education about the operation is clearly valued by anxious patients, this study is focusing on anesthesia-related anxiety in day surgery patients. Specifically, I wish to examine the possible effects of education about anesthesia on presurgical anxiety and length of post-surgery stay in the hospital.

Hypothesis

It is my hypothesis that by presenting the subject of general anesthesia in a straightforward and detailed fashion, including specific information about the experiences immediately before, during and after the general anesthesia process, some of the mystery and uncertainty will be removed from the procedure. This will provide a more relaxed and reassured surgical patient, and therefore better outcomes as measured by length of stay before discharge from the hospital after the surgical procedure, preoperative vital signs and scoring on an anxiety questionnaire.

Methods

Patients were selected from the daily surgery schedule at Fort Sanders Parkwest Hospital between February and April of 1998 and randomly assigned to either the control or experimental group. Only patients undergoing surgeries deemed to be fairly “routine” and likely to return home the same day were selected. These surgeries included: laparoscopic cholecystectomy, hernia repair, appendectomy, venous catheter insertion, and minor orthopedic surgery, including removal of hardware or foreign bodies. Patients were between the ages of 30 and 59 with an average age of 48. The control group consisted of 11 patients, 6 males

and 5 females¹, while the experimental group consisted of 12 patients, 6 males and 6 females. Data from all patients included heart rate, blood pressure and respiratory rate, recorded in the patient's room in day surgery, in pre-surgical assessment (PSA) and upon returning to the room in day surgery. Additionally, all patients filled out two questionnaires, the Penn State Worry Questionnaire (PSWQ) and the Beck Anxiety Inventory (BAI)². Control patients filled out the PSWQ first, then filled out the BAI. Experimental patients filled out the PSWQ, listened to an approximately 5 minute presentation about the general anesthesia process³, then filled out the BAI. Preoperative data collected in day surgery were collected before the administration of any pre-operative sedation. Vital signs collected in PSA were taken after the administration of pre-operative sedation, presenting possible effects that will be discussed later. Primary results were determined by the amount of time spent in day surgery after returning from post-anesthesia care unit (PACU) before being discharged from the hospital to go home. Other results were determined by comparing the scores on the BAI and vital signs recorded in PSA between the two groups. Different results were

¹There were originally 6 females in the control group but one female was excluded due to improper completion of a questionnaire.

²One item was removed from the BAI, an item concerning fear of dying, after discussion with day surgery nurses about the perhaps inappropriate nature of that particular item.

³This presentation included specific information about the nature of the general anesthesia process, including the manner by which the patient would be intubated, extubated, and some of the stimuli they could expect to encounter before going to sleep upon waking.

measured in order to increase sensitivity to any observed amount of difference or similarity between the two groups. Although postoperative vital signs were taken and recorded, it would be more difficult to assess postoperative differences in anxiety levels by analysis of these data, due to the fact that the anesthetic agent takes different amounts of time to wear off in different people.

Methodological Concerns and/or Constraints

Several potentially confounding variables must be taken into account in the analysis of the data collected in this survey. Firstly, small sample size must be considered. Also, due to the number of patients available for study and the time constraints on the surveyor, subjects were both males and females of varying ages. Based upon my experience, males and females react differently to different types of stress, so this is potentially problematic. Another important consideration is the accuracy of vital sign measurement. These measures could have been affected by variables such as conversation, room temperature, movement and even machine or human error, even though the latter two are theoretically minimal. Additionally, patients underwent different types of surgery, adding another variable of difference among group members.

Some surgeries could have been deemed more serious than others, depending on the individual and the nature and duration of his/her condition. They were, however, all same-day surgeries that are deemed fairly common and

routine, although certainly no individual would deem his/her own surgical experience “routine.” Another important consideration is that some of the indices used here to determine positive or negative results can be ambiguous because increased anxiety does not necessarily result in an extended recovery or increased hospital stay (Lepczyk *et al.* 1990). However, as cited earlier, several studies have shown correlation between anxiety levels and hospital stay, as well as other variables, such as postoperative pain medication. Another interesting and very relevant variable that could not be accounted for in this study is the perceived locus of control of the patient. According to Rotter (1966), someone with an external locus of control place much value in the role of fate, destiny and powerful others in the shaping of his/her future. Conversely, someone with an internal locus of control believe strongly in his/her own qualities and abilities in shaping the future. Therefore, an individual with an internal locus of control may react very favorably to increased knowledge of the anesthesia process he/she is about to encounter, feeling empowered by the increased knowledge. Conversely, an individual with an external locus of control receiving the same information might exhibit increased anxiety, preferring not to know medical details, perhaps feeling more secure in the knowledge that a “powerful” other (the anesthetist) would be in control of the situation. As locus of control was not tested for, this could present problems with generalizations made from a study of this sort.

Data Analysis

There were 23 patients involved in this study, 11 control and 12 experimental. A two sample *t*-test was performed comparing the two groups in order to determine whether there was any significant difference between the two groups initially. The variables compared were the preoperative vital signs (blood pressure, heart rate and respiration rate) recorded in day surgery, as well as scores on the PSWQ. An α value of $< .05$ was established as the level of significance. No significant differences were found between the control and experimental groups in any of the variables measured, as shown in Table 2.

Table 2. Two sample *t*-test comparing experimental and control group measures in day surgery

	Experimental		Control			
Variable	Mean	Standard Deviation	Mean	Standard Deviation	<i>t</i>	α
Systolic BP	129.87	11.20	132.09	7.19	-.550	NS*
Diastolic BP	84.11	9.8	85.45	7.16	-.493	NS
Heart Rate	83.47	5.39	81.91	6.77	-1.130	NS
Respiration Rate	17.91	2.61	18.36	2.01	-.75	NS
PSWQ	45.40	9.06	43.73	10.43	-1.22	NS
BAI	8.57	5.34	9.45	4.78	-1.57	.05 < α < .10

*Not Significant

In order to ascertain any significant results of the study, a two sample *t*-test was then performed for the two groups for compared scores on the BAI and the vital signs (blood pressure, heart rate, respiration rate) taken in pre-surgical assessment (PSA), after leaving day surgery. Experimental subjects would have been exposed to the presentation on the general anesthesia process by this juncture, immediately before completing the BAI. Patients in the experimental group showed significantly lower diastolic blood pressures in PSA than the control group ($\alpha < .025$), as shown in Table 3. Difference in score on the BAI and postoperative time in day surgery before discharge approached significance as well. Differences in heart rate, systolic blood pressure and respiration rate were

not statistically significant (Table 3), but difference in heart rate produced an α slightly less than .10.

Table 3. Two sample *t*-test comparing experimental and control group measures in PSA and time before discharge

	Experimental		Control			
Variable	Mean	Standard Deviation	Mean	Standard Deviation	<i>t</i>	α
Systolic BP	135.43	10.71	139.55	7.67	-1.355	NS*
Diastolic BP	85.41	7.92	87.55	6.99	-2.300	< .025
Heart Rate	81.72	6.76	83.18	5.67	-1.340	NS
Respiration Rate	19.09	1.59	19.36	1.91	.844	NS
Postoperative time in day surgery before discharge	164 min	40 min	171 min	35 min	-1.041	.05 < α < .10

*Not Significant

A *t*-test was used to compare variables measured in day surgery to those measured in PSA within each group as well. The control group showed significant increases in both systolic and diastolic blood pressures and respiration rates, but not in heart rate, while the experimental group showed only significant increase in systolic blood pressure (Table 4 and 5).

Table 4. Control group means, standard deviations and *t*-test results

	Day Surgery		PSA			
Variable	Mean	Standard Deviation	Mean	Standard Deviation	<i>t</i>	α
Systolic BP	132.09	7.19	139.55	7.67	15.540	< .01
Diastolic BP	85.45	7.16	87.55	6.99	-12.351	< .01
Heart Rate	81.91	6.77	83.18	5.67	-1.155	NS*
Respiration Rate	18.36	2.01	19.36	1.91	-10.000	< .01

*Not Significant

Table 5. Experimental group means, standard deviations and *t*-test results

	Day Surgery		PSA			
Variable	Mean	Standard Deviation	Mean	Standard Deviation	<i>t</i>	α
Systolic BP	129.87	11.20	135.43	10.71	-11.340	< .01
Diastolic BP	84.11	9.80	85.41	7.92	-.691	NS*
Heart Rate	83.47	5.39	81.72	6.76	-1.277	NS
Respiration Rate	17.91	2.61	19.09	1.59	-1.157	NS

*Not Significant

Conclusions

Patients that received detailed information concerning the general anesthesia process before surgery had significantly lower levels of anxiety than patients who did not receive this information (control group). Patients in the experimental group showed significantly lower diastolic blood pressures in PSA compared with patients in the control group. Additionally, experimental group patients had differences in BAI scores and postoperative stays in day surgery that approached statistical significance. Also, control and experimental patients showed no significant difference in scores on the PSWQ, suggesting a similar susceptibility to anxiety due to worry or fear. Within group analysis showed significant increases in all variables except heart rate in control group patients, whereas experimental group patients showed significant increase in diastolic blood pressure only.

Although these results suggest at least partial validation of the original hypothesis, several factors must be taken into consideration before generalizing information from this study. Firstly, as mentioned earlier, the sample size was quite small, only 23 total. To sufficiently test this hypothesis would require examination of a much larger population. Another key variable not tested for in this study was whether or not patients had taken any anti-anxiety medication on or before the day of their surgery. Also, as mentioned earlier, differing effects of age,

sex and perceived locus of control should be taken into account when examining these and/or similar data. Interestingly, both groups showed some increase in each of the measured vital signs between day surgery and PSA, with the exception of heart rate in the experimental group, which decreased slightly. Whereas this slight decrease could be attributed to a possible anxiolytic effect of the anesthesia information, it could also be due to a pre-operative sedative given in day surgery.

Other interesting and quite relevant variables that could not be accounted for in a study of this scope were religion, support system, ethnic background and mental history. Some patients were alone while awaiting surgery, others had friends and/or family accompanying them. Group prayer, either with or without the presence of a preacher, priest, chaplain or other religious leader is often conducted before surgery, perhaps serving to relieve anxiety in some patients. Patients from different ethnic backgrounds may respond differently to stress and certainly patients with any history of mental disturbance would exhibit different levels of anxiety, ranging from extremely high to extremely low. In short, there exists nearly infinite variables contributing to a patient's level of anxiety. Though controlling for all of these at one time may be impossible, their varying effects should be taken into consideration, not only in analysis of such data, but in design of such future studies.

Recommendations

Given the small sample size represented in this study, these data can be interpreted as pilot data at best. The aforementioned constraints upon the methodology of the study should also be taken into consideration. However, there are some relevant results that warrant further study of this type. Further research of this type should include data concerning other relevant variable, such as the patient's perceived locus of control and perhaps additional physiological indicators of anxiety, such as the galvanic skin response. This study supports the importance of preoperative teaching in the reduction of anxiety. Preoperative education is not just common, but required by law in relation to the surgical procedure, i.e. informed consent. This study indicates at the very least a need to further explore the ramifications of preoperative instruction regarding the anesthesia process as a possible method for reduction of presurgical anxiety.

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Appendix A. Patient Data

Table 6. Patient Data - Control group in Day Surgery

Patient	Systolic BP	Diastolic BP	Heart Rate	Resp. Rate	PSWQ	BAI
1	120	74	80	20	50	2
2	128	79	78	18	40	13
3	124	96	96	16	36	10
4	130	92	86	19	54	15
5	136	88	84	20	44	7
6	144	95	89	22	30	4
7	132	85	82	17	56	12
8	140	86	79	16	32	6
9	127	78	72	16	62	18
10	138	80	74	18	40	9
11	134	87	81	20	37	8
Mean	132.09	85.45	81.91	18.36	43.73	9.45
Stan. Dev.	7.19	7.16	6.77	2.01	10.43	4.78

Table 7. Patient data - Control group in Presurgical Assessment (PSA) and post-op stay in day surgery

Patient	Systolic BP	Diastolic BP	Heart Rate	Respiration Rate	Post-op stay in day surgery (min)
1	135	84	86	18	130
2	132	82	85	20	170
3	155	98	81	20	245
4	142	94	90	22	180
5	138	89	86	18	150
6	150	99	91	22	195
7	130	82	80	18	145
8	144	88	85	18	170
9	134	80	76	17	125
10	136	79	72	18	165
11	139	88	83	22	200
Mean	139.55	87.55	83.18	19.36	170
Stan. Dev.	7.67	6.99	5.67	1.91	35

Table 8. Patient data - Experimental group in Day Surgery

Patient	Systolic BP	Diastolic BP	Heart Rate	Respiration Rate	PSWQ	BAI
1	116	78	81	15	34	3
2	146	90	84	22	56	17
3	119	70	85	16	32	4
4	144	94	89	21	46	2
5	120	88	78	16	50	14
6	140	90	85	15	55	11
7	121	72	90	20	36	4
8	139	92	76	17	43	14
9	138	94	86	21	58	14
10	120	73	77	19	44	5
11	134	74	79	16	53	13
12	121	94	92	17	38	4
Mean	129.87	84.11	83.47	17.91	45.40	8.57
Stan. Dev.	11.20	9.8	5.39	2.61	9.06	5.34

Table 9. Patient data - Experimental group in Presurgical Assessment (PSA) and post-op stay in day surgery

Patient	Systolic BP	Diastolic BP	Heart Rate	Respiration Rate	Post-op stay in day surgery (min)
1	123	84	76	18	125
2	149	86	84	21	140
3	121	76	86	19	236
4	146	95	89	20	190
5	130	86	86	18	196
6	145	96	72	19	135
7	126	76	90	19	135
8	147	92	74	18	195
9	143	94	85	21	130
10	123	78	75	17	215
11	130	74	75	17	146
12	141	88	89	22	125
Mean	135.43	85.41	81.72	19.09	164
Stan. Dev.	10.71	7.92	6.76	1.59	40

Appendix B. Anxiety tests - Beck Anxiety Inventory (BAI) and Penn State Worry Questionnaire (PSWQ)

Below is a list of symptoms. Please read each item in the list carefully. Indicate how much you have experienced each symptom TODAY ONLY using the scale below.

0-----1-----2-----3
Not at all Mildly Moderately Severely

- ___ 1. Numbness or tingling.
- ___ 2. Feeling hot.
- ___ 3. Wobbliness in legs.
- ___ 4. Unable to relax.
- ___ 5. Fear of the worst happening.
- ___ 6. Dizzy or lightheaded.
- ___ 7. Heart pounding or racing.
- ___ 8. Unsteady.
- ___ 9. Terrified.
- ___ 10. Nervous.
- ___ 11. Feelings of choking.
- ___ 12. Hands trembling.
- ___ 13. Shaky.
- ___ 14. Fear of losing control.
- ___ 15. Difficulty breathing.
- ___ 16. Fear of the unknown.
- ___ 17. Scared.
- ___ 18. Fear of complications while under anaesthesia.
- ___ 19. Indigestion or discomfort in abdomen.
- ___ 20. Faint.
- ___ 21. Face flushed.
- ___ 22. Sweating (not due to heat).

1. If I do not have enough time to do everything, I do not worry about it.
2. My worries overwhelm me.
3. I do not tend to worry about things.
4. Many situations make me worry.
5. I know I should not worry about things, but I just cannot help it.
6. When I am under pressure I worry a lot.
7. I am always worrying about something.
8. I find it easy to dismiss worrisome thoughts.
9. As soon as I finish one task, I start to worry about everything else I have to do.
10. I never worry about anything.
11. When there is nothing more I can do about a concern, I do not worry about it any more.
12. I have been a worrier all my life.
13. I notice that I have been worrying about things.
14. Once I start worrying, I cannot stop.
15. I worry all the time.
16. I worry about projects until they are all done.