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Editorial

Current opinion about surgery-related fear and anxiety

Undergoing a surgical procedure is a major life event for many and can lead to stressors such as heightened fear and associated anxiety. The fear of undergoing surgery or an invasive medical procedure is correctly termed 'tomophobia' and lifetime prevalence is estimated at 12.8 per cent¹. In Australia, over 2.3 million people report anxiety disorders, with females at greater risk of anxiety (17.9 per cent) than males (10.8 per cent)². With 2.5 million surgical procedures occurring in Australia each year³, an estimated 320 000 Australians experience tomophobia as a surgical patient (assuming prevalence of 12.8 per cent). However, some populations are more likely to experience surgery-related fear and anxiety: especially females⁴⁻⁶, older adults with fewer social supports⁷, those with lower levels of education⁷⁻⁸, those undergoing prolonged or major surgery⁵ and those with fewer overall levels of social support⁹.

For all who experience surgery-related fear and anxiety, the impact of psychological stress is far from trivial. Preoperative fear and anxiety can lead to increased post-operative depression and anxiety¹⁰, prolonged wound healing¹¹⁻¹², extended length of hospital stay¹³, additional dosing of anaesthetic drugs¹⁴ and more use of analgesics after surgery¹⁵. The mechanisms behind these adverse surgical outcomes are likely to involve psychophysiological stress responses associated with preoperative anxiety, the physical trauma of surgery¹⁵, and its influence on post-operative adjustment and recovery¹⁶. However, further



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high-quality studies are needed to expand on the associated risks of tomophobia in surgery patients. With the evidence indicating the condition is both widespread and leads to surgical complications, how can we address surgery-related fear and anxiety?

Firstly, there is a need to preoperatively screen patients appropriately. In a 2014 cross-sectional study, preoperative anxiety screening is recommended for all patients to both identify the extent of the problem and report surgical complications associated with the condition¹⁷. Several validated surveys are specifically available for surgery-related fear and anxiety including the Amsterdam preoperative anxiety and information scale (APAIS)¹⁸, bypass grafting fear scale (BGFS)¹⁹ and the surgery stress scale (SSS) for knee surgery²⁰. Several generic scales are also available including the state-trait anxiety inventory (STAI)²¹ and the hospital anxiety and depression scale which has been validated in the preoperative context^{22,23}. These tools are brief and conducive to most patients being able to complete them independently. However, it is not clear whether all patients should be screened or a subset of those most at risk of preoperative anxiety (i.e. females, older adults, patients undergoing prolonged or major surgery, and those with lower levels of education and social support).

Secondly, there is a need to better understand what interventions are effective for reducing preoperative fear and anxiety. The longstanding association between surgery and psychological stress including fear

and anxiety is well known²⁴ and leads to the argument that the stressors of surgery may be modifiable by psychological or supportive care interventions. However, few effective interventions are available to treat surgery-related fear and anxiety. In a 2015 systematic review of preoperative interventions to reduce anxiety and improve surgical recovery, the effects of educational interventions were inconclusive²⁵. A 2016 study showed that individualised empathic interviewing yielded reductions in overall patient anxiety and improvements in recovery time, wound healing and patient satisfaction²⁶ while a similar psychosocial intervention led to reduced anxiety in cardiac surgery patients²⁷. For children undergoing surgical procedures, audio-visual interventions appear to be effective for reducing fear and anxiety associated with surgery²⁸. Throughout the literature, the importance of integrating sources of social support for patients such as family and friends into the care process is emphasised^{6,9} indicating a place for family-centred care in the perioperative environment.

Implications

Although studies correlating surgery-related anxiety and fear with a range of adverse outcomes is weak, both evidence and logic indicate preoperative anxiety is a widespread condition which needs addressing. Current practice in treating anxiety appears to range from psychoeducation²⁸ to sedation¹⁴. For the latter, sedating people without first appealing to their humanity and honouring the privilege of caring for people at their most vulnerable reflects perioperative care at its least caring.

Interventions for surgery-related anxiety represent an opportunity to improve care by perioperative

nurses taking leadership in treating it as they would any other condition. Although proving both the clinical and economic benefits of such interventions is necessary, there is a need to move beyond long-standing, self-limiting professional concepts in which technical skills trump holism. This means perioperative nurses must prioritise the provision of nursing care ahead of passing instruments. There is ample evidence to suggest operative outcomes can be improved through optimising healthy behaviours that enhance nutrition, exercise, sleep and psychological well-being; however, the role of perioperative nurses in these contexts is under-researched and therefore under-developed. With so many perioperative initiatives working towards optimising surgical outcomes²⁹⁻³², it is time that nurses become enterprising and develop interventions targeting the plethora of unmet needs among people undergoing surgery.

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