

Psychopathology and illness beliefs influence COPD self-management

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Abstract

Objective: To explore the influence of psychological characteristics in Chronic Obstructive Pulmonary Disease (COPD) self-management. **Methods:** Patients admitted with an exacerbation of COPD were interviewed for psychiatric symptoms, illness beliefs and self-management behaviour using a new COPD Self-Management Interview (COPD-SMI). This comprised three scenarios to mimic a future evolving exacerbation. Responses were scored for knowledge and actions (adherence) for each scenario. **Results:** Of 47 people approached, 39 participated; 41% had panic attacks, 33% general anxiety, 35% a depression history, 31% an anxiety history and 21% an alcohol dependence history. Twenty-six (67%) had a self-management plan. When hypothetically “well” lower (poorer) COPD-SMI Knowledge Scores were associated with an alcohol dependence history ($P=.025$), no panic ($P=.021$) and males ($P=.028$). Those perceiving less influence over COPD had lower Action Scores during this scenario ($P=.01$) and the “early

exacerbation” scenario ($P=.05$). Lower Knowledge Scores for the “early exacerbation” were associated with no panic ($P=.01$) and no self-management plans ($P=.03$). For the “severe exacerbation”, lower Action Scores were associated with depression history ($P=.004$), panic ($P=.002$), higher FEV₁% and no self-management plans ($P=.005$). Higher PaCO₂ was associated with lower confidence in symptom recognition, self-management ability and medical care influencing COPD. **Conclusion:** Anxiety, depression, alcohol use and illness beliefs may differentially influence self-management. Depression, previous alcohol dependence and perceived less influence over COPD inhibited self-management. Those with panic demonstrated more self-management knowledge when “well” but performed poorly on actions during the “severe exacerbation”. Those with self-management plans had better knowledge and actions.

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Introduction

Chronic Obstructive Pulmonary Disease (COPD) is a slowly progressive lung disorder characterised by airflow obstruction [1]. Typically, patients experience acute episodes of exacerbation, which may include increased breathlessness, cough or sputum production and require altered self cares and additional medication [1]. This condition is one of the most expensive chronic medical disorders. It is among the four major causes of avoidable hospitalisation for New Zealanders aged 45 and over [2]. The average length of stay in New Zealand hospitals is 6.2 days with a total cost of 16.4 million per annum [2]. Morbidity rates for COPD are

expected to increase in the next 20 years placing a significant economic burden on health care services [2].

Written self-management plans, which have previously been successful in reducing hospital admissions in asthma [3], have been instigated in New Zealand to encourage COPD patients to respond quickly to impending exacerbation with the potential to reduce hospital admissions [4]. Such plans comprise written information with specific instructions regarding management when symptoms deteriorate. A small ($n=56$) randomised controlled study of a nationally adopted COPD Action Plan in primary care indicated that such plans can increase early intervention behaviours with regard to oral corticosteroids and antibiotics but did not show differences in lung function or quality of life [4].

Evaluation of patient's self-management knowledge and capacity to act on that knowledge is fundamental to any

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self-management plan that aims to improve independent performance of health-related behaviours [5–7]. Methods of assessing patient knowledge vary. Self-report questionnaires have the advantage of easy nonexpert administration and limited responses [6]. Whilst more expedient, these approaches do not create the conditions in which disease knowledge must be applied. Another approach, which aims to overcome this problem, involves an interview using disease-specific hypothetical scenarios. Scenarios have been used to explore patients' self-management knowledge in asthma [6–8]. Such scenarios can identify self-management behaviour, which includes delays in calling for emergency services and not initiating oral corticosteroids in a timely manner [8].

The impact of psychological characteristics such as anxiety, depression, alcohol use and illness beliefs on self-management behaviour during an exacerbation of COPD has not been evaluated. This is despite a growing number of studies indicating that anxiety and depression are common in people with moderate/severe COPD [9–11]. Few studies have gone beyond examining the relative prevalence of these disorders. Theoretically, anxiety and depression may influence self-management in a number of ways. Anxiety is thought to enhance motivation to learn, however, it can also lead to misinterpretation of body symptoms and potentially incorrect self-management actions [12,13]. Conversely, depression is known to decrease motivation to perform activities [14]. This implies that the impact of these variables on self-management behaviour may be complex with potentially positive and negative consequences.

There are two areas in which alcohol may impact on self-management behaviour in COPD, i.e., learning difficulties and adherence. Prolonged heavy alcohol intake has been associated with difficulty in learning new information [15]. In COPD, no studies have directly addressed this issue. Only one study appears to have examined the impact of alcohol use and adherence in mild lung impairment. This study found that high alcohol consumption was associated with failure in attempts to quit smoking [16].

Patient's negative perceptions of their illness and ability to self-manage have been associated with nonadherence in a number of conditions [17,18]. Very few studies have addressed illness beliefs in COPD. One study has indicated that those who have difficulty in accepting their diagnosis may have less confidence to self-manage [19]. In other chronic diseases, negative patient beliefs about the ability to influence symptoms have been associated with nonadherence to rehabilitation and self-management regimens [20]. Extrapolating this to COPD, it might be expected that patients who perceive greater influence over their symptoms would have better self-management adherence.

The aim of this study was to explore the influence of patients' psychological characteristics (i.e., anxiety, depression, alcohol and illness beliefs) on self-management knowledge and behaviours by using structured scenarios to mimic an evolving exacerbation of COPD.

Method

Participants

Participants were recruited from a nonacute, 12-bed, cardio-respiratory ward located at Burwood Hospital, Christchurch, New Zealand. Typically, patients admitted to this ward are transferred from acute wards in a 660-bed general hospital when they were considered medically stable, responding to treatment and able to mobilize with one assistant. The ward aims to provide self-management education for patients as they recuperate. Patients who meet the above criteria are referred on the basis of bed availability and hence not all potentially suitable patients are admitted to this ward. The respiratory physician (GI Town) and clinical psychologist (CA Dowson) in the study team determined the inclusion criteria for this study. These were the following: (1) a primary admitting diagnosis of an exacerbation of COPD; (2) that patients had previous self-management education and were capable of self-management (excluded hospital level care, intellectual disability, etc.); (3) that the patient was considered well enough by medical staff to be interviewed; and (4) that the admission was not an anticipated terminal event. All patients who fulfilled the inclusion criteria and were present on the ward during recruiting days (Tuesday and Friday) over a 20-week period were invited to participate.

Procedure and measures

Each participant was interviewed [psychiatric assessment, illness beliefs and COPD Self-Management Interview (COPD-SMI)] for approximately 1 hour by the senior clinical psychologist.

Psychiatric assessment

This section of the interview included diagnostic questions using DSM-IV criteria for both past and current major depression, anxiety disorder subtypes (panic disorder, agoraphobia, general anxiety disorder) and alcohol disorders (abuse and dependence) [21]. A clinical interview was selected as the relative prevalence of the various subtypes (anxiety, depression and alcohol) were unknown in COPD and hence the investigators felt that an interview would be more flexible and less arduous for unwell patients in exploring these areas. Interview responses were compared with admission questions about these disorders recorded by ward staff on a multidisciplinary assessment form. Inconsistent responses between the interview and multidisciplinary form were then clarified with participants.

Assessment of illness perceptions (AIP)

Six study specific questions in a five-point Likert-type response format measured participant perceptions of their health and perceptions of COPD self-management know-

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