PSYCHOSOCIAL EVALUATION AND TREATMENT IN CHRONIC RESPIRATORY DISEASES

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Healthy Lungs For A Healthy Life!
HUMAN

- Bio
- Psycho
- Social
• **COPD** is a severe and treatment resistant pulmonary disease with varying impact on the patients’
• **general physical condition,**
• **functioning**
• **quality of life.**
• The association between chronic respiratory disorders and psychiatric disorders, in particular generalized anxiety, panic anxiety and depression, has been acknowledged for many years.

• The prevalence of psychiatric comorbidity in these patients as well as the effect of treatment and the prognosis ????????
• There is evidence that psychiatric comorbidity contributes significantly to the functional impairment of COPD patients

• Psychiatric treatment may improve not only psychiatric status but also pulmonary function
• Patients react emotionally to the discomfort of dyspnea, the loss of functional capacity and the threat of suffocation and death.
• Dyspnea, like pain is subjective, clearly influenced by emotional and psychiatric factors

• Dyspnea may be felt as a sensation of suffocation and is overwhelmingly frightening.
MAIN PSYCHIATRIC FINDINGS

- Depression
- Anxiety and panic
- Sexual dysfunction
- Cognitive impairment
Depression

- Depression can range from a
- Mild dysthymia
- Adjustment disorder with depressed mood
- to a major depressive episode.
Anxiety and Panic

- Panic disorder, subsyndromal panic and expectation anxiety often accompanies the respiratory symptoms
Sexual Dysfunction and Cognitive Impairment

- Inhibited sexual excitement
- Inhibited orgasm
- Premature ejaculation
- Cognitive impairment generally in geriatric patients
Depression
- Depressed mood
- Loss of interest
- Motor retardation
- Hopelessness
- Low self-esteem

Anxiety
- Fatigue
- Weight loss/gain
- Sleep disturbance
- Agitation
- Irritability
- Difficulty concentrating
- Thoughts of death
- Muscle tension
- Shortness of breath
- Chronic worry
- Palpitations
- Nausea
- Numbness
- Fear of loosing control

Sexual dysfunction

Cognitive impairment
Importance of Psychiatric Symptomatology (I)

- Patients with stable chronic obstructive pulmonary disease (COPD) who show significant signs of depression may also have an increased risk of mortality.
- COPD patients with depressive symptoms have a significantly higher risk for exacerbations.
- Neuropsychological dysfunction is generally evident in problem-solving deficits.
Importance of Psychiatric Symptomatology (II)

- Impaired quality of life and restricted activities of daily living
- Cognitive deficits:
  a) difficulty in monitoring the intensity of their symptoms
  b) reduced adherence to their medications
  c) poor quality of life
Early screening and diagnosis!!!!!!!

- How????????
- Mini Mental Status Examination
- Hospital Anxiety and Depression Scale
- Clinical interview according to DSM IV-TR
PSYCHOSOCIAL EVALUATION

• A thorough assessment of both the patients and the family to determine whether there are specific psychodynamic conflicts, behavioral triggers, or environmental issues that contribute to exacerbation of the respiratory illness.
PSYCHOSOCIAL EVALUATION

I

• Asthma have been proposed to have a significant psychosomatic component
• Some somatic complaints may result from behavioral conditioning
• Clasically its known that separation anxiety triggers the asthmatic attacks.
PSYCHOSOCIAL EVALUATION II

- Developmental life stage during which the patient develops respiratory disease is important.
- Children with severe respiratory disease
  - perceived and treated differently by family and friends
  - significant alterations in the relationship with mother
  - later susceptibility to the trauma of separation or other psychological impairments
PSYCHOSOCIAL EVALUATION

III

- Experience of fear of drowning
  +
- Frequent trips to the emergency room

- Pervasive anxiety
PSYCHOSOCIAL EVALUATION

IV

- Middle aged or old aged patients
- Long-standing plans disturbs
- May results with depression
- High risk of suicide and anxiety
PSYCHOSOCIAL EVALUATION

• COPD patients restricts both activating (anger / anxiety) and nonactivating (depression / withdrawal) affects to avoid the experience of dyspnea.

• A “personality trait” may result from behavioral reactions to the illness, rather than be a cause of illness.
SOCIAL COGNITIVE THEORY

• Perceived self-efficacy is a persons’ appraisal of his or her ability to perform effectively or completely in a designated situation

• A strong sense of self-efficacy is necessary for a sense of personal well-being

• Allows for persevering in efforts toward success
SOCIAL COGNITIVE THEORY I

• Self-efficacy expectations vary on 3 dimensions that have an important effect on performance

• 1) Magnitude: Level of difficulty of the task. Some individuals may feel capable of performing only simple tasks (i.e., low-magnitude expectations), whereas others have feelings or competency about performing complex tasks (i.e., high-magnitude expectation).

• 2) Generality: The extent that a domain of behaviour can be generalized to other situations. For example, if patients with COPD are successfully in performing an activity (such as stair climbing) when supervised, they may anticipate being successful when performing the activity unsupervised.

• 3) Strength: The confidence individuals have in the accomplishment of a specific task
• The objectives of structured education can be formed to increase expectations of self-efficacy thereby assisting patients in their efforts to manage, or avoid, breathing difficulty while engaging in certain activities.
SOCIAL COGNITIVE THEORY

III

- Self-efficacy is enhanced or influenced by four different mechanisms.
  - 1) Mastery experience
  - 2) Modelling
  - 3) Social persuasion
  - 4) Judgement of bodily states.
EDUCATION

• Illness
• Drugs
• Apparatus
• .......
THE TRANSTHEORETICAL MODEL (TTM)

• Used to describe the dynamic process by which individuals come to adopt and maintain changes in health behaviors.

• This model asserts that individuals move through five stages of motivational readiness for exercise adoption.
## TTM-I

<table>
<thead>
<tr>
<th></th>
<th>Precontemplation: Not currently active and not intending to increase physical activity</th>
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<tbody>
<tr>
<td>1</td>
<td>Discuss the harmful effects of the patient’s inactivity</td>
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<tr>
<td>2</td>
<td>If patient attempted physical activity in the past but was unsuccessful, problem - solve reasons that led the patient to resume a sedentary lifestyle</td>
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<td>3</td>
<td>Discuss ways in which the patient’s inactivity affects his or her family and friends</td>
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<td>4</td>
<td>Encourage patient to read and think about the benefits of physical activity for him or her</td>
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<tr>
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<td>Contemplation: Not currently active but intending to be more active in the next 6 months</td>
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<tr>
<td>1</td>
<td>Discuss the benefits of physical activity for the patient</td>
</tr>
<tr>
<td>2</td>
<td>Encourage patient to read and think about the benefits of physical activity</td>
</tr>
<tr>
<td>3</td>
<td>Problem-solve ways to decrease the patient's perceived barriers of physical activity (e.g. not enough time, fear of injury, no energy etc.)</td>
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<td>4</td>
<td>Encourage patient to set short-term activity goals (one 5-minute walk over the next week)</td>
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<td>C</td>
<td>Preparation: Occasionally active but not on a regular basis</td>
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</tr>
<tr>
<td>1</td>
<td>Problem-solve ways to decrease barriers to more regular exercise</td>
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<tr>
<td>2</td>
<td>Help patient to set short-term activity goals</td>
</tr>
<tr>
<td>3</td>
<td>Instruct patient to provide himself / herself with rewards for meeting activity goals</td>
</tr>
<tr>
<td>4</td>
<td>Discuss ways to substitute more active leisure pursuits for sedentary ones (e.g., take a short walk after dinner rather than watch TV)</td>
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<td>5</td>
<td>Ask patient to post reminders to become more active around his or her office / home</td>
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### TTM-IV

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<tr>
<th>D</th>
<th>Action: Regularly meeting suggested physical activity criterion for less than 6 months</th>
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<tbody>
<tr>
<td>1</td>
<td>Schedule follow-up visits for physical activity</td>
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<tr>
<td>2</td>
<td>Provide social support by asking how exercise is going; praise patient for his or her success</td>
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<td>3</td>
<td>Help patient plan for times of inactivity (e.g., sickness, vacation, increased work demand, bad weather)</td>
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<td>4</td>
<td>Encourage patient to try alternative forms of activity to prevent boredom and burnout</td>
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<tr>
<td>5</td>
<td>Instruct patient to provide himself / herself with rewards for meeting activity goals</td>
</tr>
<tr>
<td>6</td>
<td>Ask patient to post reminders to become more active around his or her office / home</td>
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**TTM-V**

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<td><strong>E</strong></td>
<td><strong>Maintenance:</strong> Regularly meeting suggested physical activity criteria for 6 months or more</td>
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<tr>
<td><strong>1</strong></td>
<td>Schedule follow-up visits for physical activity</td>
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<tr>
<td><strong>2</strong></td>
<td>Continue to provide social support for patient’s activity</td>
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<tr>
<td><strong>3</strong></td>
<td>Help patient develop strategies for self-monitoring his or her progress</td>
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<tr>
<td><strong>4</strong></td>
<td>Plan for risky situations for inactivity</td>
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<tr>
<td><strong>5</strong></td>
<td>Problem-solve ways to resume activity if relapse occurs (e.g., avoid all-or-nothing thinking)</td>
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Thank you