

Services Provided:

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Melanie S. Weitzenfeld, Ph.D.

Contact Information

Colorado Health Psychology
7995 E. Prentice Ave, Suite 207
Greenwood Village, CO 80111
P: 303.596.0454
F: 888.299.1224

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www.coloradohealthpsychology.com

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Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is "a disease state characterized by airflow limitation that is not fully reversible. The airflow limitation is usually both progressive and associated with an abnormal inflammatory response of the lungs to noxious particles or gases" (NIH, 2001). COPD can cause coughing that produces large amounts of mucus, wheezing, shortness of breath, chest tightness, and other symptoms. Approximately 80% to 90% of those at risk for COPD smoke cigarettes

(American Thoracic Society, 1995). The risk of COPD, in turn, increases as a function of the number of cigarettes a person smokes daily. Smoking is associated with three types of disease conditions: emphysema, small airway inflammation and fibrosis, and mucus gland hyperplasia (Senior & Anthonisen, 1998). While cigarette smoking is the leading cause of COPD, long-term exposure to other lung irritants, such as air pollution, chemical fumes, or dust, also may contribute to the develop-

ment of COPD. Although defined in behavioral parameters (i.e., the amount of coughing that occurs during a certain number of months each year), chronic bronchitis can also be produced by smoking. Chronic bronchitis, in addition to emphysema, is a major form of COPD.

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melanie@coloradohealthpsychology.com

COPD and Anxiety www.nationaljewish.org

Deep in our brain is a region that constantly samples our blood to be sure that we are breathing well, and that we are breathing clean "healthy" air. If it detects anything wrong with our breathing or the air around us, it can send out an alarm signal that something is wrong. This might feel like a sudden rush of anxiety or even panic. This feeling is supposed to prod us to get up and get away from whatever dangerous situation has caused our breathing to set off our "suffocation alarm."

With COPD, patients regularly have trouble breathing and their suffo-

cation alarm can become hyperactive. They may feel anxious or edgy. Even little changes, like strong odors or being hurried, can set off a full suffocation signal. This is the reason that patients with COPD frequently complain of increased episodes of panic and anxiety.

With help from their physician and/or psychologist, patients can be helped to "reset" their suffocation alarm and feelings of anxiety. The approaches may include breathing retraining, psychotherapy, and medications.



Some patients experience excessive worry and anxiety, and others do not experience enough. There is an "ideal" level of worry. At this ideal state, the patient has an understanding that they have a chronic and challenging illness. They are aware of the things they can do to help and hurt their experience with the illness. Over the course of their illness, patients will likely go through periods when they worry too much and others when they should give their illness more consideration. This is normal, and it is important for patients to find the right amount of worry that can help them keep their life and illness in balance.

COPD Statistics



- COPD is the fourth leading cause of death in the U.S. and is projected to be the third leading cause of death for both males and females by the year 2020 (www.copd-international.com)
- 12.1 million adults 25 and older were diagnosed with COPD in 2001 (www.nhbli.nih.gov)
- The worldwide prevalence of COPD in 1990 was estimated to be 9.34 men per 1,000 and 7.33 women per 1,000 (NIH, 2001)
- It is estimated that in 2000, 2.74 million people died of COPD worldwide (WHO)
- In 2004, approximately 11.4 million American adults had COPD, about 3.6 million people had emphysema, and 9.0 million people had chronic bronchitis (www.lungusa.org)
- COPD claimed 122,283 American lives in 2003 (www.lungusa.org)
- Approximately 80% to 90% of those at risk for COPD smoke cigarettes (American Thoracic Society, 1995)
- Unlike other lung diseases, White Americans are more prone to develop COPD than other racial or ethnic groups. Not only are they more at risk to develop the disease, but they are also more likely to die from it (www.lungusa.org)
- The chronic bronchitis prevalence rate for Hispanics (25.0 per 1,000) was significantly lower than for both Whites (44.1 per 1,000) and African Americans (36.4 per 1,000) in 2004 (www.usalung.org)

Behavioral Treatment of COPD Boll, 2004

In addition to medications, two behavioral approaches comprise the triumvirate of treatment for COPD: Smoking cessation and rehabilitation of patients.

“Smoking cessation is the single most effective—and cost-effective—intervention to reduce the risk of developing COPD and stop its progression (NIH, 2001). To achieve this goal, brief tobacco dependence treatment is recommended for every tobacco user. In addition, three types of counseling—practical counseling, social support as part of treatment, and social support outside of treatment—are recommended as approaches to take in curbing smoking. If these prove ineffective alone, the NIH has suggested that effective pharmacotherapies be combined with counseling if needed and in the absence of contraindications.

The report by the NIH (2001) emphasized the importance of rehabilitation in the treatment of patients with COPD. The report identified the principle goals of

pulmonary rehabilitation are to “reduce symptoms, improve quality of life, and increase physical and emotional participation in everyday activities.” The report suggested that the achievement of these goals requires resolving a range of nonpulmonary problems, including exercise conditioning, social isolation, altered mood states, muscle wasting, and weight loss. At all stages of COPD, patients benefit from exercise training programs; they improve with respect to exercise tolerance, symptoms of dyspnea, and fatigue.

Initial attempts to rehabilitate patients with COPD have centered around providing exercise training to improve physical function and quality of life. A meta-analysis of pulmonary rehabilitation and COPD found positive benefits were attained in programs in which exercise was the main rehabilitative component (Lacasse et al., 1996).

Numerous investigators have described

the benefits of rehabilitation for patients with COPD, including improved exercise tolerance, the perception of dyspnea, and quality of life (e.g., Foglio et al., 1999; Goldstein et al., 1994; Young et al., 1999). One study (Toshima et al., 1990) described improvements in self-efficacy that were correlated with improvements in exercise, and another (Janelli et al., 1991) recommended that pulmonary rehabilitation programs teach appropriate coping strategies to patients with COPD.

Other investigators have been more multidisciplinary and oriented toward using behavioral skills in rehabilitation programs for COPD. These skills include self-management, exercise promotion, functional training, building and enhancement of social skills, and techniques designed to optimize the medical management of COPD (e.g., medication adherence). Other components include patient and family education, training in coping with the condition, and development of self-efficacy in patients.