

Does Anxiety and Depression Impact Patients with COPD?

A common reason for medical emergency treatment is the acute exacerbation of obstructive pulmonary disease. Relapses in acute asthma and decompensated chronic obstructive pulmonary disease (COPD) are often the cause of these return visits to the emergency department and do not correlate with the severity of the patient's disease. One study found that psychosocial factors, such as being widowed or divorced, were closely related to relapses in male patients with COPD. Dahlén and Janson conducted a study to determine if psychologic factors predicted outcome after emergency treatment of patients with acute exacerbations of obstructive pulmonary disease.

The study population consisted of patients 18 years of age or older with an acute exacerbation of obstructive pulmonary disease, asthma, or COPD, who presented to an emergency department at a university hospital. Patients were excluded from the study if they were immediately admitted to the hospital or if they were unable to perform pulmonary function tests. Patients underwent spirometry, blood sampling, and pulse oximetry. In addition, breathing rate, pulse rate, and dyspnea score were measured before and during emergency treatment. All participants received basic emergency treatment for the exacerbation of obstructive pulmonary disease. The psychologic status of each patient was assessed at follow-up four weeks after the initial emergency treatment. The hospital anxiety and depression (HAD) questionnaire was used. At the follow-up visit, researchers also reviewed hospital records to identify any relapses that required treatment of obstructive pulmonary disease.

The study evaluated 43 patients (mean age: 65.3 years), and approximately 40 percent (17 patients) of these patients were identified by the HAD questionnaire as having anxiety and/or depression. Patients who were found to have anxiety or depression were significantly more likely to be admitted to the hospital or to have a relapse within one month of the initial emergency department visit. Patients who had a relapse within one month had significantly higher scores on the HAD scale than those who did not have a relapse. When adjustments were made for variables such as age, gender, atopic status, treatment, and pack-years, the association between treatment failure and anxiety and/or depression remained significant.

The authors conclude that anxiety and depression are related to the outcome of emergency treatment in patients with acute exacerbations of obstructive pulmonary disease. The authors add that additional research should be conducted to determine if the treatment of anxiety and depression in these patients can reduce the number of relapses of acute exacerbations of their obstructive pulmonary disease.

KARL E. MILLER, M.D.

Dahlén I, Janson C. Anxiety and depression are related to the outcome of emergency treatment in patients with obstructive pulmonary disease. Chest Nov 2002; 122:1633-7.

Abstract of Original Article

Anxiety and depression in COPD: How much do they contribute to physical symptoms and functional status?

Background

The aim of our study was to assess the prevalence of anxiety and depression in the whole chronic obstructive pulmonary disease (COPD) population and in subgroups according to sex and severity classification. A secondary objective was to evaluate the possible differences between patients with and without a significant high level of anxiety, depression, or both, and finally to find out a correlation between psychological aspects, symptoms, functional parameters, and quality of life (QoL).

Methods

Two hundred and two COPD patients were enrolled. Their levels of anxiety, depression, dyspnoea, and QoL were assessed using specific questionnaires. One hundred and fourteen sex- and age-matched healthy subjects were used as the control population.

Results

The prevalence's of anxiety and depression were high (28.2% and 18.8%) in COPD even when it was of mild degree, compared to the control group, in which the prevalence of anxiety and depression were 6.1% and 3.5%, respectively. Female patients had higher levels of anxiety and depression and worse symptom-related QoL. Female patients reported a higher level of dyspnoea than males for the same level of ventilatory impairment. Dyspnoea was more strongly correlated with depression in women than in men.

Conclusions

Anxiety and depressive symptoms are common in patients affected by COPD, even when their disease is mild in terms of FEV₁ and respiratory symptoms. Female patients appear to be more exposed to psychological impairment, which correlates well with some specific symptomatic aspects of the disease, such as dyspnoea. Psychological aspects need to be carefully assessed in COPD patients, particularly in females.

Abstract

Anxiety and depression are common in patients with COPD. This study confirms the high prevalence of psychological morbidity in these patients. The authors examine whether disease severity and gender determine the prevalence of psychological symptoms and whether anxiety and depression correlate with patients' symptoms and health-related quality of life.

Prevalence of Anxiety and Depression in Patients with Severe COPD: Similar High Levels with and without LTOT

Abstract

The benefits of long-term oxygen therapy (LTOT) on mood in Chronic Obstructive Pulmonary Disease (COPD) are unproven. Longitudinal studies are affected by disease progression, the increased package of care (with LTOT) and may not control for known confounders on mood. We compared the point prevalence and severity of mood disturbance

in patients with severe COPD, not on LTOT (the – LTOT group) to those with COPD on LTOT (the + LTOT group). We mailed the Hospital Anxiety and Depression (HAD) Score to 182 consecutive patients with severe COPD, identified from respiratory case notes in three UK Hospitals. We compared 57 patients not prescribed LTOT to 57 patients on LTOT, and used stratified sampling to match the groups as far as possible for age, gender, lung function and other possible confounders on mood. Of these, 25% of patients in both groups scored in the 'definite' case range for anxiety (HAD score ≥ 11). 37% of the – LTOT group and 33% of the + LTOT group scored in the 'definite' range for depression (HAD score ≥ 11) ($p = N.S$). In both groups, only 11% of responders were prescribed anxiolytics and/or antidepressants. Further multi-regression analysis confirmed that socio-demographic variables (e.g., lives alone, feels isolated or recent life events) were stronger predictors of mood than the prescription of LTOT or other traditionally accepted factors such as co-morbidity or the use of antidepressants or anxiolytics. High levels of anxiety and depression are present in severe COPD and appear under-treated. The + LTOT and – LTOT patients had a similar high prevalence of anxiety and depression.

Keywords: Chronic Obstructive Pulmonary Disease; Mood; Oxygen.

Emotional Aspects of COPD

Summarized by Robert W. Griffith, MD

February 13, 2006

Introduction

Chronic obstructive pulmonary disease (COPD) is the 4th leading cause of death in the USA today. It is an extremely distressing complaint, inducing depression, anxiety, and panic disorder in as many as 42%, 50%, and 32% of its victims, respectively. It's therefore incumbent on the treating physician to be aware of these emotional components, and to treat them accordingly. Unfortunately, it's been found that less than a third of healthcare providers identify anxiety and depression in their patients. In a disease like COPD primary care physicians are in a position to improve the quality of life of their patients, provided they recognize and treat the emotional disorders that are so common.

The reason for emotional problems

The symptoms of depression, anxiety, and COPD may overlap, to a certain extent – rapid and difficult breathing, sweating, and palpitations. The lung disease may have a relatively poor long – term outlook, leading understandably to feelings of frustration, hopelessness, and helplessness. Depressed mood lowers the energy level still further, making the symptoms even less tolerable.

Anxiety is created by the unpredictable nature and fear-arousing symptoms of respiratory distress. This distress is closely allied to panic; the patient may interpret COPD-related breathing difficulty as life-threatening suffocation, or harmless chest pains as a heart attack.

Diagnosing the problem

The symptoms of depression in association with COPD are the same as those for other patients – depressed mood, loss of interest or pleasure, sleep disturbances, weight changes, fatigue, poor concentration, and even thoughts of death.

Anxiety is shown by restlessness, muscle tension, loss of concentration, and irritability. If physical symptoms predominate – shortness of breath, chest pains, tingling sensations, trembling, feelings of faintness and choking – it's labelled panic disorder.

It can be hard to distinguish anxiety symptoms from those of COPD itself. However, anxiety should be suspected when the symptoms seem excessive for the actual stage of COPD.

Assessing the patient

If the symptoms suggest a diagnosis of depression, anxiety, or panic, the patient can be screened by a number of suitable tests. There's one screen called PRIME-MD that contains two depression and three anxiety screening questions that have been validated for use in COPD:

1. In the past month, have you been bothered a lot by; – little interest or pleasure in doing things – feeling down, depressed, or hopeless?

2. In the past month, have you been bothered a lot by: – "nerves", or feeling anxious or on edge: – worrying about a lot of different things?

3. During the past month: – have you had an anxiety attack (suddenly feeling fear or panic)?

Every depression screening questionnaire should also contain a question regarding possible suicidal thought processes.

Treatment choices

Both drug and non-drug treatments are suitable for the emotional problems encountered in COPD patients. It's advisable to explain these to the patient, and find out which approach they would prefer.

The non-drug treatment options include exercise therapy, short-term psychotherapy, and cognitive behavioural therapy ¹. Although primary care physicians or staff can provide some of the simple forms of CBT, expert assistance will be necessary in many cases. A suitably trained psychotherapist can help explain the links between the symptoms of COPD itself and the emotional overlaying condition.

Some patients may prefer to begin with drug treatment - antidepressants have a definite place in such cases. In particular, selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac®), or a newer drug, venlafaxine (Effexor®), may be given; they have anti-anxiety properties as well.

The older antidepressants - the tricyclic drugs like amitriptyline (Elavil®) - should be held in reserve, as they have pronounced side effects; benzodiazepines (like Valium®) should be avoided, as they tend to depress respiration.

Conclusions

Emotional problems like depression, anxiety, and panic, worsen the symptoms of COPD. The healthcare professional should be aware that they may be present, should screen for them, and treat them if present. This will improve the patient's quality of life considerably, which is important for someone suffering from such a distressing disease.

Source

- *Chronic obstructive pulmonary disease: Assessing and treating psychological issues in patients with COPD* BA. Burgess, KME. Kunik, SMA. Stanley, 2005, vol. Geriatrics, pp. 1818 – 1821

Footnotes

1. *Cognitive behaviour therapy (CBT) combines two very effective kinds of psychotherapy – cognitive therapy and behaviour therapy. Behaviour therapy helps you weaken the connections between troublesome situations and your habitual reactions to them, such as fear, depression, or anger. It teaches you how to calm your mind and body, so you can feel better, think more clearly, and make better decisions. Cognitive therapy shows you how certain thinking patterns are causing your symptoms, by giving you a distorted picture of what's going on, and making you anxious, depressed or angry. When combined into CBT, behaviour therapy and cognitive therapy provide powerful tools for stopping your symptoms and getting your life on a more satisfying track.*

COPD – anxiety and low health status lead to more re-hospitalisations

Main Category: [Respiratory / Asthma](#)

Article Date: 28 Aug 2005 - 21:00 PST

Patients with chronic obstructive pulmonary disease (COPD) are commonly frequently admitted to the hospital for acute exacerbations of their disease. Many risk factors have been identified for re-hospitalisations. They include: higher age, lower lung function and lower health status. However, very little is known about the role of depression and anxiety as risk factors for re-hospitalisations.

Therefore, Gunnar Gudmundsson (Landspítali University Hospital, Reykjavik, Iceland) and his North European colleagues studied a total of 406 patients from one university hospital in each of the five Nordic countries: Denmark, Finland, Iceland, Norway and Sweden.

They followed them for one year and studied how many had been re-hospitalised during that time. The Hospital Anxiety and Depression Scale that measures anxiety and depression, and St. George's Respiratory Questionnaire (SGRQ) that measures health status, were applied to all patients.

The number of patients that had a readmission within 12 months was 246 (60%). Patients that had a readmission had lower lung function and health status. The risk of re-hospitalisation was also increased in subjects with anxiety and in subjects with low health status. The patients that had the least activity had the highest risk of being admitted to the hospital.

This study identifies new risk factors for re-hospitalisation in patients with COPD and draws attention to the role of anxiety and health status in patients with COPD.

This may have important implications for treatment of patients with COPD.

The European Respiratory Journal is the peer-reviewed scientific publication of the European Respiratory Society (more than 7,000 specialists in lung diseases and respiratory medicine in Europe, the United States and Australia).

COPD CAUSED ANXIETY AND DEPRESSION

by *SirGan*



SteadyHealth.com



These last couple of years, COPD has been a subject of many studies, especially, to find out is there a link between COPD and depression or anxiety! We will try to answer some of the most important question related to this subject! What exactly is COPD? Well, it is a short-term for **chronic obstructive pulmonary disease**. It represents one chronic lung disease that includes two main illnesses: chronic bronchitis and emphysema. Unfortunately, it is also

important to point out that, presently, there is no cure for COPD. What should we know about anxiety and depression that appear often in patients diagnosed with COPD?

Signs and symptoms of COPD

What are the most common symptoms of COPD? Well, there are a lot of symptoms but the main is definitely dyspnea, or irregular and short breathing lasting for months or perhaps years. This irregular breathing is sometimes accompanied by wheezing, and a persistent cough with sputum production. This sputum is interesting because it may contain blood, usually due to damage of the blood vessels of the airways.

If we talk about some serious cases of COPD, then we should know that it can also be accompanied with cyanosis caused by a lack of oxygen in the blood.

How do lungs normally work

The human lungs are one very interesting and extremely complex organ with a very large surface area which main purpose is the exchange of oxygen and carbon dioxide between the body and the environment. Like we already know- our lungs have 2 main parts: bronchial tubes and alveoli – air sacs. So the process is rather simple! We breath and the air goes through our wind pipe, and then through bronchial tubes and into alveoli. From the alveoli, oxygen goes into blood while carbon dioxide moves out of blood. Well, this is when the individual isn't diagnosed with COPD! In cases that the person has the COPD, a process is a bit different because the lining in bronchial tubes gets red and full of mucus.

It is reasonable to assume that this mucus blocks tubes, and makes it hard to breathe. In cases of emphysema, alveoli are irritated and because of that – they get stiff and can't hold enough air.

What are the possible causes of COPD

There are many possible causes of COPD but the most common, which are responsible for 99% of all COPD cases, are:

Cigarette smoking

Every patient should be aware of one devastating fact- definitely the primary factor of COPD is chronic tobacco smoking. In the United States, around 90% of cases of COPD are due to smoking. Don't get me wrong- this isn't some rule and not all smokers will develop COPD, but smokers have at least a 25% risk. Keep this in mind every time you light your cigar!

Occupational pollutants

Experts are saying that some occupational pollutants, such as cadmium and silica, also can contribute to the development of COPD. The people at highest risk for these pollutants include coal workers, construction workers, metal workers and cotton workers, amongst others.

Air pollution

Urban air pollution may be a contributing factor for COPD as it is thought to impair the development of the lung function. In developing countries indoor air pollution, usually due to biomass fuel, has been linked to COPD, especially in women.

Genetics

Very rarely, there may be a deficiency in an enzyme known as alpha 1-antitrypsin which causes a form of COPD.

Other risk factors

Increasing age, male gender, allergy, repeated airway infection and general impaired lung function are also related to the development of COPD.

Functional Impairment in COPD Patients

Well, the right question is there and how strong is the link between some functional impairments and COPD! Several researches done in the past have confirmed that there is a strong relationship between functional status and co-morbid anxiety and depression in elderly patients with chronic obstructive pulmonary disease (COPD). The study has been conducted on 43 male veterans with COPD which also suffered from anxiety, depression, and functional status impairment. What authors concluded is that their COPD contributed to their depression, and anxiety. Anxiety and depression contributed significantly to the overall variance in functional status of COPD patients. Bad thing is that only few patients were receiving any treatment for anxiety or depression.

Do anxiety and depression impact patients with COPD?

How did experts come to the idea that depression and anxiety, and emotional status in generally, have anything to do with the primary disease – COPD? Well, one study found that psychosocial factors, such as being widowed or divorced, were closely related to relapses in male patients with COPD.

That's why – we can assume that if psychological factors predicted outcome emergency treatment of patients with acute exacerbations of obstructive pulmonary disease, there is a strong link between them!

There is also one another study that included several patients which were observed after the initial emergency treatment! The psychological status of each patient was assessed four weeks after the initial emergency treatment. What was concluded? Well, the hospital anxiety and depression questionnaire was used. Study has showed that approximately 40 percent of these patients were identified by the HAD questionnaire as having anxiety and/or depression. Not only that they were diagnosed with anxiety and depression, but their primary disease – COPD was much more serious! They were significantly more likely to be admitted to the hospital or to have a relapse within one month of the initial emergency department visit.

Overcoming Depression and Anxiety in COPD

After all that we have said- the one thing is sure – depression in people with COPD is reported to be far more common than in the general population. Although the studies confirmed this fact- the fact is also that even in the general population, 1 in 8 people would experience clinical depression more than once. What is the exact cause of this depression? Although, the exact answer is still unknown – experts assume that it was like with all other major chronic illnesses. Patients think that are incapable of normal functioning! Although, the depression is high in all chronic diseases the fact is that the incidence of depression appears to be higher in people with COPD than with those with other major chronic conditions. Some

scientists are even talking that depression affects almost all people with COPD. Why should depression be more prevalent in COPD?

Smoking and COPD

Some are even saying that some chemicals normally found on tobacco nicotine can be the possible of depression! The fact is that smokers have a higher rate of depression than individuals in the general population. We should also be aware of one fact, we know that depressed adolescents are more likely to start smoking and continue smoking. Therefore, many depression – predisposed teens start smoking early, get hooked on nicotine and later develop COPD.

One another study showed that almost 85% of patients with emphysema had, on average, 10 pack years of smoking before COPD was diagnosed!

Depression & breathing deficiency

Is there a real connection between the depression and breathing deficiency commonly seen in patients with chronic obstructive pulmonary disease! Probably the answer is YES! How come? Well, experts do know that people tend to experience breathing difficulties for a long time before they consult a physician and are finally diagnosed with COPD. This could be the biggest problem because several researches done in the past showed that, by the time people are diagnosed with COPD, on average, they have already lost 50% of their lung function! Can you imagine this?

Hypoxia- the key of the answer

What exactly breathing has to do with depression – where the connection is? Well, it is well know that the brain normally consumes about 40% of the oxygen we breathe! That's why, it is logical to assume that, it's possible that compromised breathing over time creates a chronically diminished supply of oxygen called "hypoxia." This hypoxia could be the key of the answer because with combinations with other negative physical conditions such as lesions, infarctions, and injuries and insults to the brain they can easily contribute to the cognitive impairment and depression. Conclusion is simple- this compromised breathing may be one of the reasons that the incidence of depression is higher in COPD than in other chronic conditions. That's why; the good news is that special breathing techniques provide effective treatment for chronic depression. This should definitely be in future used as a tool or treatment technique for treatment of depression!

ANXIETY AND DEPRESSION IN COPD:

Anxiety and depression in COPD: How much do they contribute to physical symptoms and functional status?

Available online 1 February 2007:

Abstract of Original Article

Background

The aim of our study was to assess the prevalence of anxiety and depression in the whole chronic obstructive pulmonary disease (COPD) population and in subgroups according to sex and severity classification. A secondary objective was to evaluate the possible differences between patients with and without a significant high level of anxiety, depression, or both, and finally to find out a correlation between psychological aspects, symptoms, functional parameters, and quality of life (QoL).

Methods

Two hundred and two COPD patients were enrolled. Their levels of anxiety, depression, dyspnea, and QoL were assessed using specific questionnaires. One hundred and fourteen sex- and age-matched healthy subjects were used as the control population.

Results

The prevalence's of anxiety and depression were high (28.2% and 18.8%) in COPD even when it was of mild degree, compared to the control group, in which the prevalence of anxiety and depression were 6.1% and 3.5%, respectively. Female patients had higher levels of anxiety and depression and worse symptom-related QoL. Female patients reported a higher level of dyspnea than males for the same level of ventilatory impairment. Dyspnea was more strongly correlated with depression in women than in men.

Conclusions

Anxiety and depressive symptoms are common in patients affected by COPD, even when their disease is mild in terms of FEV₁ and respiratory symptoms. Female patients appear to be more exposed to psychological impairment, which correlates well with some specific symptomatic aspects of the disease, such as dyspnea. Psychological aspects need to be carefully assessed in COPD patients, particularly in females.

Abstract

Anxiety and depression are common in patients with COPD. This study confirms the high prevalence of psychological morbidity in these patients. The authors examine whether disease severity and gender determine the prevalence of psychological symptoms and whether anxiety and depression correlate with patients' symptoms and health-related quality of life.

RESPIRATORY DISEASE: Caring for the carers of chronic lung disease sufferers in the community *Author(s): Helen Parnell*

Abstract:

Helen Parnell describes the needs of an often overlooked group of carers - those who look after relatives with respiratory disease. She discusses the need for government policy to more actively recognise their important role in community care.

Helen Parnell RN, DipN (Lond) is a Respiratory Nurse Specialist, Airways Clinic, St Helier Hospital, Carshalton

Article accepted for publication November 2000.

Keywords:

Respiratory disease Carers Case ideologies

There is evidence to suggest that carers of the chronically sick are disadvantaged socially and are further disadvantaged in their access to services and benefits. This article intends to examine the particular problems of carers of patients with chronic obstructive pulmonary disease (COPD), relating this to social policies and attitudes both past and present.

A shift in the profile of illness from acute to chronic or long term, has been increasing since the introduction of the National Health Service in 1948, due in part to an increasingly aging population and technological advances that have improved survival from acute trauma and illnesses (Scrambler, 1991).

Chronic chest diseases are a major cause of disability and death in the UK. In 1992, chronic bronchitis or emphysema, accounted for 6.4 per cent of all male and 3.9 per cent of all female deaths (OPCS, 1993). Although these mortality rates are significant, morbidity as illustrated by progressively spiralling disability, time off work, premature retirement, increasing use of primary and secondary care services and dependency on state benefits illustrate the real impact of COPD (Crawford, 1997).

Symptoms

Defined as a chronic slowly progressive disorder characterised by airflow obstruction, which does not change markedly over several months, lung function impairment is mostly fixed although some reversibility may be produced by bronchodilator therapy. This results in the persistent symptoms of breathlessness and fatigue, restricting mobility, which in turn leads to social isolation and poor self esteem (British Lung Foundation, 1996).

The burden of chronic illness has enormous consequences for the families of sick patients who for the large part find themselves taking on the role of the prime, unpaid care provider. The term carer has come to apply to a person providing care for someone at home, usually a family member but sometimes extending to friends or neighbours. Few have any training and are unpaid but often have a demanding role (Twigg, 1990).

Numerous studies have illustrated their value. Good social support, in particular the presence of a spouse has positive effects on coping, adaptation and quality of life in chronically ill COPD patients (Unger & Jacobs, 1995; Yohannes et al., 1998). But the cost to carers themselves in terms of isolation, depression, lack of income and social support can be significant in this patient group (Cossette & L'vesque, 1993; Keele-Card et al., 1993).

Chronic illness and disability are strongly class related (Townsend & Davidson, 1982; Field, 1993), those in the lower socio-economic groups being the most affected. There is a strong link between poverty and ill health that in turn is associated with class suggesting that those who are least well off are more subject to inequalities in health, health provision and prevention. Class differences expose them to factors which promote health or cause disease. For example poorer members of society are unable to afford the recommended healthy diet (Webb & Tossell, 1999), yet recent research has indicated

diet as having a great effect on the development of chronic lung diseases (Meidema, 1993; Tabak et al., 1999). Smoking, the greatest risk factor for COPD and exposure to occupational factors from manual unskilled jobs, such as mining, soldering and foundry working are highest amongst males in the lower socio-economic groups.

COPD patients and their families tend to be members of this group and are often elderly as symptoms become intrusive usually in the fifth and sixth decades of life. Pensions often reflect an individual's class and social status. As a result more women, retired manual workers and ethnic minorities are disproportionately represented in old age as being on the 'margins of poverty' (Webb & Tossell, 1999). A reliance on state benefits may be a consequence if forced to retire early and carers may not be entitled to benefits in their own right. The financial burden is increased by the costs of disability such as home alterations (e.g. stairlifts), additional heating, help in the home or transport (Young, 1995).

Inequalities

The Black Report (1980) identified inequalities in health within the welfare state and made recommendations rejected for the large part by government on the grounds of cost. Some were specifically aimed at the poverty/disability link and included prevention, a more comprehensive disablement allowance, housing adapted to the disabled and a shift to community care. There was no provision for carers as such, but the intention was to lessen some of the disadvantages suffered by working class people suffering disabilities which would then have a knock on effect for carers. The King's Fund report in 1995 and the recently published Rowntree report (Williams et al., 2000), confirmed that the problems are continuing and worsening. As a result the Labour government appointed a minister of public health to tackle these inequalities but its impacts are yet to be seen on carers.

The General Household Survey (1995) identified 5.7 million carers, a larger workforce than the NHS and Social Services combined, of whom 60 per cent were women (Webb & Tossell, 1999) and it is women who have traditionally been seen as the carers within the family.

Early functionalist sociologists saw the family as made up of the interconnected roles of its members. Women's roles were seen as nurturing and caring within the home allowing men to join the labour market. These roles were seen as an accident of biology that kept capitalist society functioning, but also ensured that caring was viewed as a woman's duty not an appropriately waged occupation. Later, feminist sociologists such as Anne Oakley argued that this division of labour was a product of culture rather than biology, that it was the male dominated structure of society which ensured women's work, such as caring, continued to be undervalued. A prime example of this is the Invalid Care Allowance which was not made available to women until 1986, the premise being that women were expected to care for their sick relatives and therefore required no additional finance.

There are of course also many male carers suffering the same strains, however, they are less likely to perform personal care tasks and are more likely to receive additional support from health and social services than women (Field, 1993) thereby reinforcing the gender bias.

If we add to these observations the facts that care is not generally considered to be skilled, is labour intensive, is not economically productive, is regarded as a moral duty or vocational occupation, the costs of which could not easily be met by state, it is unsurprising that support for carers has for the large part been kept off the political agenda (Webb & Tossell, 1999).

Since the 1980s however, significant changes in perceptions and ideology have highlighted concerns. A body of research from the feminist camp has exposed the exploitative, gendered nature of informal care (Twigg et al., 1990) whilst the development of conservative and neo-liberal social and political thought shifts the

emphasis of care on to the family caring for it's own rather than in more formalised care settings. This ideology is closely linked to economic arguments and is interested in support rather than replacing informal care (Twigg et al., 1990).

Informal care has been heightened on the political agenda for a number of reasons, changes in family patterns as a result of rising divorce rates and co-habitation together with women's move into the labour market may signal less informal carers will be available (Twigg et al., 1990) whilst the anticipated rise in the elderly population with a corresponding fall in available family support would increase the cost of care required. Elderly carers may require care themselves.

Community care

The policy of shifting care from institutions into the community has been promoted by successive governments since recommendations for such a change in the care of mental patients were made by a Royal Commission in 1957. Supported care within the family was seen as an integral and desirable aspect of this community service (Lewis, 1994). Unfortunately, this transfer of services has not always been accompanied by appropriate funding or political will.

The 1970 Chronically Sick and Disabled Persons Act for example, made it a statutory duty for local authorities to build up a picture of the needs of local people with disabilities in order to address them but few authorities carried out comprehensive studies. Service provision remained inadequate and uneven, dependent upon place of residence (Young, 1995). This act also ensured that local authorities had a specific duty to make an assessment of need and then decide on what provision should be made. However, a House of Lords ruling in 1997 upholding Gloucestershire County Council's appeal that it could take it's own finances into account when assessing need for a client opens the door for services to be provided only if resources are available (Webb & Tossell, 1999). Various carer groups have banded together to try and overturn this ruling.

Positive response

Research clearly indicated that the presence of an informal carer significantly reduced the chance of someone receiving state care (Lewis, 1994) consequently the government responded positively to a strong campaign mounted by carer's associations, feminist researchers and the Equal Opportunities Commission aimed at addressing carers financial and service needs. The Community Care Act 1990 saw family, friends and neighbours as being central to care in the community. Community care has always been a mixture of provision from family and neighbours, the state, private and voluntary sectors but with this Act the Thatcher government advocated increased voluntary sector involvement along with a renewed emphasis on family care for all its dependents thereby appearing to minimise government responsibility for carer support.

There is no doubt that voluntary and charitable services can make a difference to carers but their impact can be difficult to assess as they may be the only resort and therefore much needed (Field, 1993). Access may be difficult through lack of awareness or services being limited to specific diseases. Patients diagnosed as having cancer for example can benefit from palliative care provided by the Macmillan or Marie Curie Hospice schemes which would be denied to the end stage chronic respiratory patient who may be equally as needy.

Here too, the government could be accused of exploiting women and getting care on the cheap as women make up the bulk of those running or providing voluntary services.

In its favour, the voluntary sector can respond rapidly to change according to needs and can be a way of limiting control by the professions (Weir, 1993) yet valuable in voicing needs to professionals. They can act as change agents campaigning for carers as the Carers National Association has done with some success.

Self-help groups can be helpful to both sufferers and carers (Field, 1993). The British Lung Foundation's Breathe Easy Group, for example, supplies its members with

information and at its best can provide invaluable psychological support encouraging members to stay active. However, it can be argued that the running of such groups is essentially a middle class activity and once again relies heavily upon unpaid women (Weir, 1994). Nevertheless, in the absence of more formal support, such voluntary services can be of great use to carers and in recognition of this many authorities are working with national groups to try to support carers (Webb & Tossell, 1999).

Overall in real terms the Community Care Act saw less being provided by the state, as social services departments found themselves trying to implement changes in the face of local authority budget cuts, resulting in very varied experiences of intervention with many people finding it irrelevant to their needs confusing and fragmentary (Webb & Tossell, 1999).

Impact

Perhaps only the Carer's (Recognition and Services) Act, 1995, can be seen as a brave attempt to formally acknowledge the plight of carers and raise their profile as it entitles them for the first time to an assessment of their own needs for support. However, once again no extra funding has been forthcoming and it has yet to make any profound impact (Webb & Tossell, 1999).

As a group, carers remain disadvantaged. They already shoulder the greater part of the burden of community care. The carers of COPD patients face particular problems which are not always addressed. New ideologies have shifted the focus of provision away from the State to individuals, their families, the voluntary and independent sectors, the aim being to reduce benefits and foster independence. The question remains how this can be achieved as in view of their relatively low status and poor support carers are marginalised and socially excluded despite being the victims of social, political and economic processes (Webb & Tossell, 1999).

References

- British Lung Foundation. (1996) The Lung Report - Lung disease: a shadow over the nations health. BLF publication.
- Calverly, P. (ed) (1996). 'Smoking cessation: professional problem or public policy?' *Resp Med* 90: 123-124.
- Clipp, E., George, L. (1992). 'Patients with cancer and their spouse caregivers: perceptions of the illness experience', *Cancer*, 69; 4: 1074-1079.
- Cossette, S., L'vesque, L. (1993) 'Caregiving tasks as predictors of mental health of wife caregivers of men with chronic obstructive pulmonary disease', *Research in Nursing and Health* 16; 252-263.
- Craib, I. (1992). *Modern Social theory: From Parsons to Habermas*, 2nd Ed. Harvester Wheatsheaf, Hemel Hempstead.
- Crawford, A. (1997) 'Chronic Lung Disease: an invisible disability', *Community Nurse*, 1: March: 18-2.
- Field, D. (1993). 'Chronic illness and physical disability', in Taylor S. and Field D. *Sociology of Health and Health Care: an introduction for nurses*. Blackwell Scientific Publications, Oxford.
- Giddens, A. (ed) (1992) *Human Societies*. Blackwell, Oxford.
- Gough, P., Maslin-Prothero, S., Masterton, A. (1994) *Nursing and Social Policy: care in context*. Butterworth-Heinemann Ltd., Oxford.
- Haralambos, M. (1985) *Sociology: Themes and Perspectives*, 2nd Ed. University Tutorial Press, Slough.
- Harrison, S., Hunter, D., Pollitt, C. (1990) *The Dynamics of British Health Policy*. Routledge, London.

- Hill, M. (1993) *Understanding Social Policy*, 4th Ed. Blackwell, Oxford.
- Jacobson, B., Smith, A., Whitehead, M. (ed) *The Nation's Health: A strategy for the 1990's*. King's Fund Publishing Office, London.
- Keele-Card, G., Foxall, M., Barron, C. (1993) 'Loneliness, depression, and social support of patients with COPD and their spouses, *Public Health Nursing* 10: 4; 245-251.
- King's Fund (1995) *Tackling inequalities in health: and agenda for action*. King's Fund, London.
- Klein, R. (1995) *The New Politics of the NHS*, 3rd Ed. Longman, Harlow.
- Leidy, N., Traver, G. (1996) 'Adjustment and social behaviour in older adults with chronic obstructive pulmonary disease: the family's perspective, *J of Adv Nur* 23: 252-259.
- Lewis, J. (1994) 'Choice, needs and enabling: the new community care,' in Gough, P., Maslin-Prothero, S., Masterton, A. (ed) *Nursing and Social Policy: care in context*. Butterworth-Heinemann Ltd, Oxford.
- Lobchuk, M., Kristjanson, L., Degner, L., Blood, P., Sloan, J. (1997) 'Perceptions of symptom distress in lung cancer patients: I. Congruence between patients and primary family caregivers,' *Journal of Pain and Symptom Management* 4: 3 Sep; 136-146.
- Lobchuk, M., Kristjanson, L. (1997) 'Perceptions of symptom distress in lung cancer patients: II. Behavioral assessment by primary caregivers,' *Journal of Pain and Symptom Management* 14: 3 Sep; 147-156.
- Masterson, A. (1994) 'Disability' in Gough, P., Maslin-Prothero, S., Masterton, A. (ed) *Nursing and Social Policy: care in context*. Butterworth-Heinemann Ltd., Oxford.
- Meidema, I., Feskens, E., Heederik, D., Kromhout, D. (1993) 'Dietary determinants of long-term incidence of chronic non-specific lung diseases. The Zutphen study,' *American Journal of Epidemiology* 138: 1; 37-45.
- Moore, S. (1994) *A-Level Sociology*. Letts Educational, London.
- Office of Population Censuses and Surveys. *Mortality statistics, cause: England and Wales 1992*. Series DH2 No 19. HMSO, London.
- Scrambler, G. (ed) (1991) *Sociology as applied to medicine*, 3rd Ed. Baillière Tindal, London.
- Smith, G., Bartley, M., Blane, D. (1990) 'The Black report on socio-economic inequalities in health 10 years on,' *BMJ* 301: 373-377.
- Tabak, C., Feskens, E., Heederick, D., Kromhout, D., Menotti, A., Blackburn, H. (1998) 'Title of article,' *European Journal of Clinical Nutrition* 52(II): 819-825.
- Taylor, S., Field, ?. (ed) (1993) *Sociology of Health and Health Care: An introduction for nurses*. Blackwell Scientific Publications, Oxford.
- Townsend, P., Davidson, N. (ed) (1982) *Inequalities in Health: The Black Report*. Penguin Books, Harmondsworth.
- Twigg, J., Atkin, K., Perring, C. (1990) *Carers and Services: A review of research*. HMSO, London.
- Unger, D., Jacobs, S. (1995) 'Couples and chronic obstructive airways diseases: the role of gender in coping and depression,' *Women's Health: Research on Gender, Behaviour and Policy* 1(3): 237-255.
- Webb, R., Tossell, D. (1999) *Social Issues for Carers: Towards Positive Practice*, 2nd Ed. Arnold, London.

Weir, H. (1994) 'The family and social policy' in Gough, P., Maslin-Prothero, S., Masterton, A. (ed) *Nursing and Social Policy: care in context*. Butterworth-Heinemann Ltd., Oxford.

Williams, J., Middleton, S., Townsend, D. (2000) 'Survey of poverty and social exclusion in Britain.' Joseph Rowntree Foundation, University of Bristol.

Yohannes, A., Roomi, K., Waters, K., Connolly, M. (1998) 'Quality of life in elderly patients with COPD: measurement and predictive factors,' *Resp Med* 92: 1231-1236.

Young, P. (1995) *Mastering social welfare*, 3rd Ed. Macmillan Press, London.

One person in seven in the UK is affected by lung disease.
We are here for every one of them.



BRITISH LUNG FOUNDATION

[You and your lungs](#) > [Living with a lung condition](#) > [Dealing with anxiety](#)

Dealing with anxiety

[Introduction](#)

[What is anxiety?](#)

[What causes anxiety?](#)

[Anxiety and depression](#)

[How likely am I to be anxious?](#)

[How does anxiety affect people?](#)

[What are the symptoms of anxiety?](#)

[Panic attacks](#)

[Breathing control](#)

[Techniques for dealing with anxiety](#)

[Conclusion](#)

[Help and support](#)

Home	Dealing with anxiety	Get involved
About the BLF	Dealing with depression	Media and campaigning
Supporting you	Exercise and the lungs	BLF COPD Project
You and your lungs	Going on holiday with a lung condition	Giving
About your lungs	Healthy eating and your lungs	Publications
Childhood lung conditions	How to get the best from your doctor	Research and grants
Conditions and diseases	Living with occupational lung disease	Contact us
Diagnosis and treatment	Mesothelioma care - what to expect from your local NHS	
Living with a lung condition	Nebulisers	
Air travel with a lung condition	Nebuliser suppliers	
CFC free inhalers	Oxygen	
COPD: Living with chronic obstructive pulmonary disease (COPD)	Oxygen suppliers	
Coping with breathing problems	Sex and breathlessness	
	Smoking and your lungs	
	Stopping smoking	
	Your home and your lungs	

Dealing with anxiety

Introduction

[What is anxiety?](#)

[What causes anxiety?](#)

[Anxiety and depression](#)

[How likely am I to be anxious?](#)

[How does anxiety affect people?](#)

[What are the symptoms of anxiety?](#)

[Panic attacks](#)

[Breathing control](#)

[Techniques for dealing with anxiety](#)

[Conclusion](#)

[Help and support](#)

Introduction

Living with a lung disease can affect many aspects of your life. There are the physical symptoms, like getting out of breath and feeling tired. But lung diseases can also have an effect on your feelings, and on how you cope. Many people with a lung condition feel anxious.

This aim of this page is to help you deal with anxiety.

What is anxiety?

Everyone experiences anxiety at some time in their life. In fact, it's a normal reaction to what we think is a threat or danger to us. This can be a real threat or an imaginary one - the feeling of anxiety is the same.

People often become anxious in difficult situations, like taking an exam, moving house, having an interview or going to the dentist.

These feelings of anxiety usually go away. Sometimes, they can even be useful, making us more alert and improving our performance. But if these feelings start to take over and become a big part of our lives - that's a problem.

What causes anxiety?

Lots of things can cause anxiety, and anxiety affects different people in different ways.

For some of us, anxiety starts after a long, slow build-up of stress. It can also start when we don't feel in control of certain aspects of our lives - our health, for example. This can make us feel anxious about the future in general.

A stressful event like a chest infection or a stay in hospital can cause anxiety. You might well be worried that it will happen again, for example.

Some medicines can make people feel anxious. And, of course, having a lung condition can give you symptoms that make you feel anxious too. Sometimes, the symptoms of lung disease - like tightness in the chest or getting very tired easily - are similar to feelings of anxiety.

It's not always clear what is causing anxiety. Sometimes, you can just be aware of feeling anxious all the time. When you can't understand why you're anxious, this can create a downward spiral: you can become anxious about feeling anxious. This makes you more anxious, and so on.

Anxiety and depression

It's not easy to live with a lung condition. As well as experiencing symptoms such as getting out of breath and coughing, having a lung condition may make you less active than usual. It can also mean that you don't sleep as well at night. You can lose interest in food - you may get full more quickly, or you might just get tired when you eat. These are some of the reasons why people with lung disease can also be depressed.

Depression is not the same as anxiety. The difference is that anxiety is related to fear, while depression is related to feeling hopeless. Many people live with both anxiety and depression.

The British Lung Foundation produces information on depression. It might be helpful to look at that too. If depression is also a problem for you, then understanding the difference between depression and anxiety is important so that you can deal with each one separately.

How likely am I to be anxious?

Most people feel anxious at some time in their lives. It becomes a problem when it starts to take over your life.

This is what happens:

How does anxiety affect people?

Anxiety affects people in different ways. Recognising what symptoms apply to you will help you deal with them.

Some symptoms of anxiety affect people physically, some affect how people feel or think. Have a look at the lists opposite. If some of these apply to you, you might be suffering from anxiety. If you follow some of the suggestions in this booklet then you should start to feel better and be able to get on with your life.

What are the symptoms of anxiety?

Anxiety - affects on feelings

- A sense of fear
- Unable to concentrate
- Irritable
- Less patient than you were
- Constant worrying
- Feeling on edge all the time
- Getting very tired easily
- Bad sleep
- Feeling preoccupied or obsessed with something

Anxiety - effects on the body

- Tightness in the chest
- Chest pain

- Nausea
- Quick, shallow breathing
- Loss of appetite
- Butterflies in the stomach
- Headaches and dizziness
- Tight or aching muscles
- Rapid or pounding heart beat
- Feeling faint
- Sweating
- Passing urine a lot
- Diarrhoea
- Loss of interest in sex
- Panic attacks
- Wind
- Pins and needles, especially in the hands or around the mouth
- Trembling

Panic attacks

Some people have panic attacks. This is when the feelings of anxiety take over. You feel like you might faint, pass out, be sick or even stop breathing. When this happens, people often 'over-breathe' or hyperventilate. This can be very uncomfortable and makes the situation worse. Learning to breathe properly can help with panic attacks.

Breathing control

There are five simple steps for controlling your breathing:

- 1.) Breathe out first.** At the first signs of panic, the first worrying thought about a physical symptom, empty your lungs as much as you can. Breathe out so that you feel that there's plenty of room to take a full, deep breath.
- 2.) Breathe through your nose.** This automatically slows down your breathing and helps you to avoid hyperventilating.
- 3.) Breathe deeply into your abdomen** (NB: this step is not suitable for everyone with COPD. If you have COPD please check with your health professional whether it's suitable for you. COPD: Living with chronic obstructive pulmonary disease features a number of other techniques for your condition).

Put one hand on your stomach, the other on your chest. Breathe so that the hand on your stomach moves, while the one on your chest is nearly still. By directing the breath deep into your abdomen, you stretch your diaphragm and relax tight muscles that make it seem hard to breathe.

- 4.) Count while you breathe.** Breathe out first, then breathe ...in through your nose, counting "One... two... three". Pause a second, then breathe out through your mouth, counting "One... two... three... four". The counting protects you from rapid, panicky breathing. Make sure you breathe out for one beat longer than you breathe in. This will help you empty your lungs between breaths.

5.) Slow your breathing by one beat. Breathe in and count, "One... two...three... four"; pause, and breathe out, counting, "One... two... three... four... five". As always, you breathe out one beat longer than you breathe in.

If you can slow your breathing down at the first signs of anxiety, you can very often protect yourself from the worst symptoms.

The first times you try breathing control should be in safe and relaxing environments. Don't try it for the first time when you're panicky or even anxious. Practice is the key.

Once you feel confident that you have mastered breathing control, try it in situations where you are worried about panic, or when you first notice physical symptoms (e.g. breathlessness, pressure or pain in the chest).

Techniques for dealing with anxiety

Recognising that there is a problem is the first step to dealing with it, even if you do not know what's causing the problem. Here are some ways of dealing with anxiety:

Talking

Talking to someone about the problem can make it seem more manageable. It may help if you choose to talk to someone close to you - a friend or a member of your family. Or you may prefer to talk to someone with a similar lung condition. The British Lung Foundation support network, Breathe Easy, can help.

Most people with anxiety can be treated by their GP. Sometimes they may suggest that you see a psychiatrist or psychotherapist, or a member of the Community Mental Health team. These are all people who can help you get on your way to recovery.

Or you might prefer to call a Helpline. If so, you'll find some numbers in the 'Help and support' section.

Relaxation

You can try this on your own, or you may prefer to join a group. Relaxation involves sitting quietly, relaxing the muscles in your body, breathing slowly and deeply and clearing your mind of all thoughts. There are lots of relaxation tapes and books available - ask at your local library or bookshop.

Physiotherapy for your breathing can also help. Speak to your doctor or nurse about this.

Exercise

It helps to be as active as possible. This will take your mind off your anxious thoughts. Keeping active will also help to keep you fit and it can help you to sleep better. Exercise can use up the extra adrenalin that comes with anxiety.

Care for yourself

How your lung disease makes you feel is unique to you - only you really know how you feel. Learn to recognise when you are feeling over-tired or becoming stressed. Then start one of the above courses of action. It should help.

Diet

Eating a balanced diet is important (whether you have a lung disease or not!). For many people, several small meals a day may be better than two or three big ones, but content and quality are important.

For further information go here to order our Healthy eating and your lungs leaflet.

Alcohol

Too much alcohol might make you feel better for a bit, but it can actually make anxiety worse - although a small glass of sherry or wine can sometimes help with your appetite or help you to relax or sleep. It's just important not to overdo it.

You should check that alcohol doesn't clash with your medication. Ask your doctor, nurse or pharmacist, or read the leaflet that comes in the packet.

Saying "no"

Learn not to take too much on. Too many demands on your time can increase your anxiety. When you say 'no' you're taking back control of your life.

Complementary therapies

Some people find complementary therapies like hypnosis, massage and acupuncture useful. But remember not to take any herbal or other remedies without checking with your doctor, nurse or pharmacist.

For further information go here to order our Complementary therapies booklet.

Medication for anxiety

Sometimes you can use medication to control your anxiety. Your GP may prescribe something called an 'anxiolytic', which is to reduce anxiety, or an antidepressant.

Get some help or support

Joining a self-help group can be useful if you want to meet people who share your experiences. You may have a local Breathe Easy group near to you. You can meet people with similar lung conditions and perhaps pick up some useful coping strategies.

Don't be afraid to ask for help. Anxiety is more common than you think.

Conclusion

Remember, everyone feels anxious at some time. And for people with a lung condition, anxiety is a common problem. Sometimes it can affect you for the worse. If this is happening to you, do ask for help. There are many ways of getting help and many people who can help you. The first step is deciding that you need to get some help.

Remember that taking the first step puts you on the road to recovery.

Help and support

Besides talking to your doctor or nurse there are organisations that offer help and advice:

Breathe Easy

Breathe Easy is the support network of the British Lung Foundation.

British Lung Foundation advice service

The British Lung Foundation helpline is open Monday to Friday, from 10am - 6pm and is staffed by benefits advisors and specialist respiratory nurses.

helpline: 08458 50 50 20

e: enquiries@blf-uk.org **w:** www.lunguk.org

Both of the following websites have 'useful links' pages which will direct you towards further sources of help.

No Panic

Helpline for people experiencing anxiety problems, open 10am - 10pm, 7 days a week. 93 Brands Farm Way, Randlay, Telford, Shropshire TF3 2JQ

helpline: 0808 808 0545

e: ceo@nopanic.org.uk **w:** www.nopanic.org.uk

First steps to freedom

Information and help for people with anxiety problems, open 10 am - 10 pm, 7 days a week.

1 Taylor Close, Kenilworth, Warwickshire CV8 2LW

helpline: 0845 120 2916