Change Strategy and Implementation

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Biopsychosocial Concepts for Advanced Nursing Practice I

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Patients often present with respiratory issues of varying severity; these can range from breathing difficulties to dry or wet coughs. Patients that do present with these issues are admitted to the pulmonary ward to treat the issue at hand. Chronic obstructive pulmonary disorder (COPD) is one of the primary issues among these. Each patient receives treatment based on the severity of his or her condition. The treatment can include prescribing antibiotics, non-invasive ventilation, and pulmonary rehabilitation. Pulmonary rehabilitation involves a program of exercise and education specifically designed to help individuals with pulmonary issues such as COPD (NHS, 2016a).

The treatment for COPD is aimed at improving the physical health of patients admitted to the ward. However, it does not take into consideration the mental health of these individuals. There exists a strong positive correlation between COPD and anxiety and depression (Pooler & Beech, 2014), which means that patients who present with COPD are likely to be comorbid with anxiety, depression, or both. Further, COPD patients who are comorbid with depression and anxiety are statistically more likely to be hospitalized; these patients are also likely to require longer periods of hospitalization and face a greater risk of mortality after they are discharged. Considering these factors, it is necessary to address mental health issues simultaneously with physical issues to ensure that these patients can manage their overall health more effectively. Left untreated, both anxiety and depression can lead to significant implications for compliance to medical treatment (Pooler & Beech, 2014).

Anxiety and COPD

Some of the symptoms associated with COPD overlap with those associated with anxiety. Dyspnea or shortness of breath is particularly distressing for patients and is common to both COPD and anxiety. A COPD patient with anxiety might interpret dyspnea in an exaggerated

manner, often correlating this symptom with an inability to breathe or even an imminent death (Heslop, Newton, Baker, Burns, Carrick-Sen, & De Soyza, 2013). Anxiety might not be the cause of dyspnea in COPD patients, but it can be viewed as an indicator of acute exacerbation in such patients (Pooler & Beech, 2014).

Depression and COPD

As mentioned above, there exists a significant correlation between COPD and depression. The effect that depression has on COPD patients is different from the effect produced by anxiety. Depression has been significantly linked to a perceived decrease in quality of life as well as in physical activity. Pooler and Beech (2014) also note that depression is likely to be underdiagnosed and undertreated for individuals with COPD.

Patients who suffer from COPD and depressive symptoms are less likely to follow through on their recommended physical therapy. Consequently, their COPD becomes aggravated, requiring them to receive further treatment. For most patients, particularly in cases of acute exacerbation, further treatment would require hospitalization. However, this might cause patients to feel that they are unable to care for themselves; they may experience inferiority or a diminished sense of autonomy. As a result, patients are often stuck within this cycle of deteriorating health, leading to a decline in the state of their mental health. The only effective method to treat patients in such a situation is to address both their physical and psychological issues (Dursunoğlu et al., 2016).

Change Strategies

Both depression and anxiety require attention from a mental health professional to adequately and effectively help patients. Cognitive behavioral therapy (CBT) has been proven to be an effective method of managing anxiety, depression, and a range of other mental health

conditions. In a typical CBT session, a patient and a therapist work together to break down one of the patient's problems into its separate parts. Some of these parts could be how the patient thinks about the problem, how he or she feels physically about it, and how he or she acts in response to it. The patient and the therapist then evaluate these parts and figure out what might be unhelpful or unrealistic as well as the effect that these parts have on each other and on the patient (NHS, 2016b).

By identifying these parts, the therapist can figure out a plan of action for the patient to change thoughts and behaviors that are counterproductive. The patient will then be asked to practice these changes in his or her life and report back on whether he or she was able to enact the changes and how effective they were. By using this method, the patient would eventually be able to apply the skills that he or she has learned in the sessions to his or her life. This would help the patient manage his or her issues even after the course of treatment is complete (NHS, 2016b). For example, individuals with COPD and anxiety might be able to better manage their anxiety by not associating shortness of breath with more catastrophic outcomes.

However, CBT has certain drawbacks. It requires patients to be willing to confront their emotions and anxieties, which can be uncomfortable. Further, CBT requires patients' commitment to the process and their cooperation to help themselves get better. The therapy can be guided, but ultimately the outcome of therapy is determined by the patients' participation (NHS, 2016b). On a practical level, it can be difficult for hospitals to accommodate an adequate number of therapists for patients or to provide an efficient therapist-to-patient ratio.

To address this, it would be necessary for group therapy sessions to be conducted in conjunction with one-on-one sessions. This would enable a wider range of individuals to access the necessary treatment for their psychological condition, and it might be less intimidating for

them if it is a group activity. Further, nurses could be trained in CBT, or those trained in CBT could be hired to facilitate more one-on-one sessions. Patients who are provided with access to these treatment options in addition to the treatment they receive for their COPD will have a higher quality of life and be able to manage both their physical and mental conditions more effectively than before (Howard & Dupont, 2014).

Pharmacological interventions can also be used to treat anxiety and depression. Treatment doses vary based on the severity of the disorder and can have a variety of side effects. Most antidepressants are not contraindicated; however, caution is necessary while prescribing certain types such as tricyclic antidepressants. Benzodiazepines have the potential to cause respiratory depression and should not be administered to COPD patients who retain CO_2. Standard antidepressants such as selective serotonin reuptake inhibitors can often have side effects such as headaches, tremors, gastrointestinal distress, and either psychomotor activation or sedation. These side effects occur during the initial phase of treatment and can be problematic when coupled with the existing conditions of COPD patients. In contrast, CBT and group therapy are nonpharmacological interventions and would not result in contraindications. It is also difficult to implement the pharmacological treatment of depression and anxiety on the level of policy as the medication and doses required would be based on the needs of individual patients. Further, patients who suffer from COPD might be unwilling to take medication for depression or anxiety along with the medication that they might already be taking. This could possibly result from the stigma that surrounds mental illnesses or the reluctance of patients to accept their diagnosis (Tselebis et al., 2016).

Data Table

Current Outcomes	Change Strategies	Expected Outcomes

Patients who suffer from COPD do not have adequate access to mental health facilities: a) Many COPD patients experience anxiety resulting from dyspnea. b) Patients with COPD are likely to experience depressive symptoms that have been positively correlated with the worsening of COPD symptoms.	To ensure that patients receive the care they need, certain measures are necessary: • Therapists should be made available to COPD patients. • Nurses should be trained in CBT, or nurses who are trained in CBT should be hired. • Group therapy sessions should be conducted regularly for COPD patients who are comorbid with anxiety, depression, or both.	Patients who suffer from COPD will have adequate access to mental health facilities and will be able to manage both their physical and mental conditions more effectively than before: a) Patients who are comorbid with COPD and anxiety will be able to distinguish between their anxiety and an aggravation of their COPD symptoms (Howard & Dupont, 2014). b) Patients who are comorbid with COPD and depression will be better prepared to manage both their COPD and their depressive symptoms (Dursunoğlu et al., 2016).

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