CHAPTER 1

INTRODUCTION

Background and significance of the research problem

Chronic obstructive pulmonary disease (COPD) is a common chronic disease that seriously harms people's health all over the world. It is the second most significant illness among the middle to older adults in the world (Johnson, 1988). In China, a survey of 60 million Chinese showed that the incidence of COPD was 3.82% and has increased with age to 15% over the age of 50 (Yang & Gao, 1993). This number probably represents only the more advanced cases, while the true number of cases may be more than that figure. COPD was found to be the second leading cause of death after cardiovascular disease among Chinese people (Li & Gao, 1989). In Changsha City, the number of patients with COPD has not been reported. However, according to the statistics of Xiang Ya Hospital in the city (Hospital report from Xiang Ya Hospital, 1999), the respective numbers of inpatients with COPD in 1997 and 1998 were 538 and 513, while the mortality rates of COPD inpatients in 1997 and 1998 were 2.79% and 1.75%, respectively. Because the Outpatient Department (OPD) has not done any record for the outpatients, the figure about the COPD outpatients seems to be underestimated.

It has been known that COPD is an irreversible, progressive chronic disease that incapacitates person physically, psychologically and socioeconomicly (Burrows, 1985; McSweeny & Grant, 1988; Sexton, 1990). It is characterized by airflow obstruction, air trapping, hyperinflation, and impaired gas exchange, resulting in a syndrome of shortness of breath, cough, sputum production, and possibly wheezing (Weilitz & Sciver, 1996). In more advanced stages, there are also poor exercise tolerance, loss of appetite, loss of weight, and easily fatigue (Shekleton, 1987). Therefore, COPD confines more individuals to bed and was found to be the fourth leading cause of restriction of major life activities (Lewis & Bell, 1995).

Because of those physical incapabilities or physical functional problems, psychosocial problems such as anxiety, loneliness, and depression were also found among patients with COPD (Keel-Card, Foxall & Barron, 1993; Schrier, Dekker, Kaptein, & Dijkman, 1990; Sexton & Munro, 1988). Since respiration is known to be essential to life, an awareness of struggling to catch one's breath arouses a fundamental panic in the COPD sufferer (Nett & Petty, cited in Sexton, 1990). This feeling contributes to anxiety, in turn, anxiety can make breathing more difficult. This cycle may create depression and hopelessness. In addition, because of impaired pulmonary function and lacking of energy to do daily activities, dependence is increased. The dependence may disturb the patients' self-esteem, make them feel less powerful, useful, and worth. The patients with COPD also

have to confront many personal losses including loss of control over activities of daily life, loss of independence, loss of self-esteem, and loss of contact with friends (Craige & Edwords, 1983). Furthermore, because of decreased energy, impairment of mobility, and spending all time on regimens and symptom control, restricted outdoor activities and social isolation are resulted in (Sexton, 1990).

COPD patients may also face economic problems. Just as Sexton (1990) pointed out, since COPD affects people mostly in their 50s which is at the peak of their productive lives, those who may be the major bread-earners are often forced into retirement. It results in diminished family income. Furthermore, the costs of treatment for COPD are quite high, frequent hospitalization, therefore, can cause the economic strain and financial-dependence. All problems faced including physical, psychological, socioeconomic limitations make COPD patients feel hopeless and dissatisfied of life, have low self-respect, and have a feeling of uselessness that reflect a negative self-concept.

According to Roy (1999), self-concept is the composite of beliefs and feelings that a person holds about himself or herself at a given time, as well as the generalizations he or she makes about self-worth, abilities, and limitation, which is influenced by interactions with environment and other persons. The self-concept includes physical self and personal self. Physical self deals with body sensation and body image. The personal self encompasses self-consistency, self-ideal, and the moral-ethical-

spiritual self. Self-concept is formed from internal perceptions and perceptions of others' reactions. Self-concept includes the person's view of his or her personality traits, social roles, and physical traits. It is always evolving and is influenced by values, beliefs, interpersonal interactions, culture, and perceptions of how one appears to others. Self-perceptions consisting of what the person believes others thinks of him or her become firmly embedded in the overall self-concept (Fuller & Schaller-Ayers, 1994).

A positive self-concept implies acceptance of oneself as a person with strength and weakness, while a negative self-concept is reflected in feelings of worthlessness and lack of self-respect (Buck, Rawlins & Williams, 1984). Persons with positive self-concept may act and appear actively, and seek more behaviors to achieve their optimal adaptation. In contrast, persons with negative self-concept indicate ineffective adaptation. The COPD patients with positive self-concept may well accept all their strengths as well as limitations, and seek effective methods to make themselves feel better. The COPD patients with negative self-concept may deny and isolate themselves more, which in turn increases frustration, anger, and despair (Lucas, Golish, Sleeper & O'Ryan, 1988), even suicide.

To adapt to all changes in body and emotion, all individuals including COPD patients require a great deal of personal strength and social support (Lucas, Golish, Sleeper & O'Ryan, 1988). According to Weiss (cited in Weinert,

1987), Brandt and Weinert (Weinert, 1987), social support is the perceived support composed of five dimensions which are provision for attachment/ intimacy, social integration, that is, being an integral part of a group, opportunity for nurturant behavior, reassurance of worth as an individual and in role accomplishments, and the availability of informational, emotional, and material help. It was shown that the social support has been implicated in the mediation of stressful life events, recovery from illness, and increased program adherence (Heitzmann & Kaplan, 1988). The social support resources are composed of subsystems, systems, and suprasystems (Phillips, 1991). As family, which is a group of two or more individuals living in close geographic proximity and having close emotional bonds (Jassak, 1992), belongs to the system of social support resource (Phillips, 1991), hence, family support is a part of social support.

As mentioned above, patients with COPD always confront many physical limitations and experience suffering in the loss of self, resulting in a negative self-concept. This type of suffering, according to Kersten's study on COPD patients (1990), comes from four sources: 1) living a restricted life; 2) social isolation; 3) discrediting definitions of the self, arising from interaction from others or from unmet expectations; and 4) burdening others, as the person becomes dependent and immobilized. Because of social isolation and immobilization, the caregiving family of the COPD patient becomes the major social field (Lucas,

Golish, Sleeper & O'Ryan, 1988). With support from family members, the patient will be motivated to adapt to the illness situation and new lifestyle and improve their physical capabilities which resulting in improving of their self-perception. In addition, being loved by family members makes patients express their feelings freely. It was shown that family support was associated with less depression, less anxiety, and better family functioning (Lee & Kang, 1991; Primomo, Yates & Woods, 1990). The patients with close family supportive relationship are more likely to have positive self-concept and vice versa. Low self-concept can cause many adverse effects to COPD patients and low family support can increase the risk of mortality and morbidity (Caldwell, 1988). It is necessary to enhance positive self-concept and family support.

Since COPD is a progressive disease, the longer the patient has disease, the more suffering he/she has. Normally, only patient with serious symptoms will be admitted for proper management, therefore, frequency of hospitalization can reflect the severity of disease. The more severe the disease, the more changes in patients' body functions, the more costs for regimens and the more multiple dependence on others. All these may result in more negative self-concept among COPD patients. At the same time, COPD impacts not only the patients, but also their family members. Family members spend a lot of energy, time, and money in caring for the patient. So, family members may also feel more stress to cope with, further, withdrawing is

experienced (Sexton, 1990). Patients with long duration of disease and with frequent hospitalization are more likely to have a low level of family support. Therefore, duration of disease and frequency of hospitalization may negatively affect level of family support.

From above, it is obvious that self-concept and family support are significant to the well-being of COPD patients. However, the information about family support and self-concept and the relationship between the two concepts among Chinese COPD patients were little mentioned in the literature review. It is certainly in need to describe them. Also the relationship between frequency of hospitalization, duration of being diagnosed, as the indicators of severity of the disease, and both self-concept and family support need to be investigated. The results from the study will be beneficial to nursing knowledge which nurses could use to guide their practice to promote COPD patients' positive self-concept, furthermore, to enhance the patients' quality of life, which is the goal of nursing care.

Objectives of the study

1. To identify the level of family support of COPD patients.

2. To identify the self-concept of COPD patients.

3. To examine the relationship between family support and self-concept of COPD patients.

4. To examine the relationship between frequency of hospitalization, duration of being diagnosed and self-concept of COPD patients.

5. To examine the relationship between frequency of hospitalization, duration of being diagnosed and family support of COPD patients

Research questions

1. What is the level of family support of COPD patients?

2. What is the self-concept of COPD patients?

3. What is the relationship between family support and self-concept of COPD patients?

4. Is there any relationship between frequency of hospitalization, duration of being diagnosed and self-concept of COPD patients?

5. Is there any relationship between frequency of hospitalization, duration of being diagnosed and family support of COPD patients?

Scope of the study

The research was conducted among 108 COPD patients attending the Outpatient Department of Xiang Ya Hospital of Hunan Medical University in Changsha, China during November 1999 to January 2000.

Assumptions

1. All people are bio-psycho-social beings.

2. Support is given and received among family members.

Definition of terms

COPD patients are patients diagnosed by physician as COPD including chronic bronchitis, pulmonary emphysema and some asthma with irreversible airflow obstruction attending the Outpatient Department of Xiang Ya Hospital of Hunan Medical University.

Self-concept is the composite of beliefs and feelings that one holds about oneself at a given time consisting of physical self and personal self (Roy & Andrews, 1999), measured by the Modified Self-Concept Scale (MSCS) which is modified by the researcher from Self-Concept Scale developed by Li (1998) based on Roy's Adaptation Model.

Family support is the perceived social support composed of five dimensions as intimacy, social integration, nurturance, worth, and assistance fulfilled by family members including parents, siblings, spouse, children and close relatives, which can be measured by the Modified Personal Resource Questionnaire 85 Part 2 (MPRQ 85 Part 2) adopted by the researcher from the Personal Resource Questionnaire 85 Part 2 (PRQ85-Part 2) (Weinert, 1988).

Severity of disease is the extent of disease consequences measured by frequency of hospitalization and duration of being diagnosed.

Frequency of hospitalization is the times of having been admitted to the Outpatient Department of the hospital due to COPD.

Duration of being diagnosed is the number of years from being diagnosed as COPD by physician to the date being investigated.