Patients with acute exacerbations of COPD saw anxiety as a sign, rather than cause, of breathlessness


How do patients describe the relation between anxiety and the experience of dyspnea (ie, perception of shortness of breath) during an acute exacerbation of chronic obstructive pulmonary disease (COPD)?

**Main Findings**

The relation between acute dyspnea and a patient’s physical and emotional functioning was the most frequent topic of stories told by patients and FCs. Emotional vulnerability stories. Emotional vulnerability was expressed as anxiety experienced in anticipation of and during episodes of increasing or intractable breathlessness that patients could not avoid or manage. In stories where the relation between emotional function and breathlessness was unclear, participants talked of emotional dysfunction as a sign of intractable breathlessness. A complex and circular relation existed between breathlessness and anxiety; participants talked of emotional dysfunction as being the result of both chronic breathlessness and increased physical or emotional activity. Giving concrete expression to the experience of dyspnea legitimised the illness and the help seeking behaviour of patients and FCs. Vulnerability was also understood in terms of patients’ perceptions of lessened capacity for interacting with perceived threats in their environments. Sometimes, unusual emotional reactions to everyday situations (eg, arguing with a relative or being in a crowd) were understood as signs of the onset of unusual breathlessness; increasing dyspnea then evoked other emotional reactions, which resulted in more breathlessness. Emotional vulnerability stories generally concluded with acknowledgement of patients’ emotional disability, decreased activity, increased experience of dyspnea, further emotional distress, and often, help seeking behaviour (eg, emergency admission to hospital).

The anxiety of dyspnea was presented as a visual expression of a patient’s subjective experience of breathlessness or the sequelae of dyspnea. Patients were seen as not being able to express common emotions without precipitating or exacerbating existing dyspnea. Emotion dysfunction as part of the experience of living with COPD, characterised by acute exacerbations. By giving dyspnea a visible form, patients’ complaints of an “invisible” experience (feeling short of breath) and their help seeking behaviours were legitimised; that is, breathlessness, concretely represented as emotional dysfunctions and vulnerability, functioned to legitimise the experience of dyspnea.

**Conclusions**

The vulnerability stories of patients with acute exacerbations of COPD and their family caregivers revealed an understanding of the dynamic relation between dyspnea and emotional functioning, specifically anxiety. Anxiety was seen not as the underlying cause of distressing dyspnea, but as a sign of longstanding or acute respiratory failure, a relation that could be described as the “dyspnea-anxiety-dyspnea cycle.” Anxiety, in effect, was seen as a signal that patients were actually breathless.
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