Adults with chronic lung disease had fatigue with laboured breathing that interfered with daily living, but coped well


**QUESTION:** What are the experiences of fatigue in adults with chronic obstructive pulmonary disease (COPD) and asthma?

**Design**
Quantitative description using content analysis of semi-structured interview data.

**Setting**
Specialist clinic and not for profit association in St John’s, Newfoundland, Canada.

**Participants**
36 participants between 28 and 81 years of age (mean age 58 y, 69% women), 17 with COPD (chronic bronchitis, emphysema, or both) and 19 with asthma, were recruited through a respiratory specialist clinic and a local lung association using purposive sampling.

**Methods**
Data were gathered from face to face interviews that lasted about 1 hour each. Interviews were guided by the “fatigue schedule”, a semistructured questionnaire to prompt discussion on characteristics of fatigue, causative and precipitating factors, associated physical and emotional feelings, the effect on relationships and everyday activities, and coping strategies and resources; however, participants were encouraged to speak freely about their experience of fatigue. Interviews were audio-taped, transcribed verbatim, and content analysed.

**Main findings**
Participants with COPD or asthma shared similar experiences of fatigue. Fatigue was described as a feeling of general tiredness and “sapped” energy that occurred daily, sometimes persistently, or with exacerbation of the disease. Fatigue was associated with laboured breathing and an inability to obtain sufficient oxygen. Participants identified 3 types of precipitants of fatigue: those that caused a flare up of the condition (eg, common cold or flu), those that caused laboured breathing (eg, physical exertion, environmental tobacco smoke, strong odours, or the weather), and those that affected their level of fatigue directly (eg, interrupted sleep). Fatigue contributed to a gradual decline in the ability to perform activities of daily living. Most participants felt that their fatigue did not interfere with their relationships with family and friends. Although fatigue caused irritability, frustration, and depression, participants felt that they coped well with it. Coping strategies were problem focused, which included energy conservation, utilisation, and restoration, and emotion focused, which included being positive, accepting physical limitations, distracting from limitations, and behaving normally (ie, not focusing on the illness but trying to maintain a normal life within the limitations).

**Conclusions**
Adults with chronic obstructive pulmonary disease or asthma described fatigue as an unrelenting feeling of tiredness that was associated with laboured breathing and that limited their ability to perform meaningful daily activities. Coping strategies included those that managed the physical symptoms and those that managed the emotional responses.

**COMMENTARY**
The findings of this study by Small et al support the current literature on fatigue in chronically ill patients and extend the understanding to patients with COPD and asthma. The coping strategies described in this study are consistent with those recently drawn from developing models of fatigue in chronic illness.

This study shows that an aspect of the fatigue experience in this population with chronic respiratory illness is laboured breathing. Many of the fatigue management strategies described in this study have also been described in studies of dyspnoea in similar populations. However, this study attempts to distinguish between the experiences of people with COPD and those with asthma: an interesting finding was that fatigue with asthma was an episodic experience that occurred during exacerbation, whereas fatigue with COPD was experienced daily. Further study is needed to more clearly identify appropriate adaptations of fatigue management strategies for those people with asthma compared with those with COPD.

The authors state that most participants coped well in spite of the adverse impact of fatigue on their functioning. This conclusion must be interpreted with caution as the research was not designed to evaluate the effectiveness of coping. Rather, one of the most noteworthy findings is the participants’ description of the impact of fatigue as affecting more than just physical aspects. This broad conceptualisation of fatigue emphasises the need to manage the emotional and social impact of fatigue as well. Participants who described family and friends who were understanding of their condition felt supported, whereas those who had difficulty coping hesitated to reveal their fatigue to others. This suggests that nurses might help their patients by fostering a shared understanding of the experience of fatigue and support for the ill person and those around them.

This study examined fatigue as it relates to physical, emotional, and social outcomes. It adds to the evidence that directs nursing practice in fatigue management and identifies further areas for evaluation of these types of interventions.

Della Roberts, RN, MScN
Clinical Nurse Specialist, Community Health Services
Vancouver Richmond Health Board
Vancouver, British Columbia, Canada