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 dyspnoea (ie, perception of shortness of breath) during an acute exacerbation of chronic obstructive pulmonary disease (COPD)?

**DESIGN**
Focused ethnography with narrative analysis.

**SETTING**
2 hospitals in a mining community in northern Ontario, Canada.

**PATIENTS**
10 family-nurse units of patients who were admitted to hospital with acute exacerbation of COPD characterised by extreme dyspnoea; had >2 previous acute exacerbations of COPD that required hospital admission; and had named family members as next of kin. The nurse-family units comprised 10 patients, 15 family caregivers (FCs), and 10 nurses.

**METHODS**
Indepth interviews were conducted during the patient’s hospital stay. Questions were based on the chronic illness model of Strauss et al, which defined acute COPD exacerbation as a medical crisis of a chronic illness. Narrative analysis was used to analyse 3 genres of the 503 stories identified from transcribed interviews: first-person event-specific stories recreating a discrete moment in time; generic or habitual stories of the general course of events over time; and kernel stories suggesting untold first-person event-specific personal stories.

**MAIN FINDINGS**
The relation between acute dyspnoea 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 dyspnoea 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 dyspnoea 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 dyspnoea, further emotional distress, and often, help seeking behaviour (eg, emergency admission to hospital).

*Meaning of emotional vulnerability stories*. Vulnerability stories helped to communicate that patients with COPD were emotionally vulnerable and that acute episodes of dyspnoea further exacerbated emotional dysfunction. *Visibility function of vulnerability stories*. Emotional dysfunction was presented as a visual expression of a patient’s subjective experience of breathlessness or the sequelae of dyspnoea. Patients were seen as not being able to express common emotions without precipitating or exacerbating existing dyspnoea. 

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