found only one quarter of people with COPD and moderate-to-severe anxiety were receiving relevant interventions (Kim et al, 2000). This may be due to a lack of awareness among health professionals, and because it is difficult to identify anxiety in the first instance. One problem is the potential confusion in distinguishing between symptoms of anxiety and those of the respiratory disease (Yohannes et al, 2010). Many scales used to screen for anxiety include somatic measures of anxiety, which can be easily confused with the somatic symptoms of COPD, such as breathlessness and heart palpitations (Fig 1).

Despite the negative impact of anxiety on quality of life and healthcare usage, there has been little research exploring the experience and impact of anxiety among people with COPD. One study examining the experiences of living with the condition highlighted anxiety and panic as particularly distressing symptoms (Barnett, 2005). However, there has been virtually no research exploring the actual experience of living and coping with panic disorders from a patient’s perspective.

**Method**

**Study design**

We used a qualitative approach to explore patients’ experiences of living and coping with symptoms of anxiety alongside COPD.

We collected data through in-depth interviews. The interviewer – who had no previous contact with participants – explained the purpose of the research and the criteria required to take part in the study to patients at pulmonary rehabilitation and community support groups. To take part in the study, individuals needed to have a primary diagnosis of COPD, have self-reported symptoms of anxiety and to be able to describe their experiences.

The study was approved by the North West-12 Lancaster NHS Research Ethics Committee and the ethics committee of Manchester Metropolitan University.

Once we had obtained written, informed consent, individual interviews were conducted at patients’ local outpatient clinics (n=5) or their homes (n=9).

**Sample**

Data was collected from a sample of 14 COPD patients. The study participants were recruited from pulmonary rehabilitation groups (n=6) and Breathe Easy community support groups (n=8) in the north west of England. The participants recruited from pulmonary rehabilitation groups were all undergoing an eight-week programme of twice-weekly rehabilitation incorporating exercise and education components. The remaining participants were members of the Breathe Easy support network, a regional network of support groups supported by the British Lung Foundation.

The participants were five men and nine women aged 43-76 years. Four were living alone at the time of the study, nine lived with their spouse and one lived with an older parent. On average, participants had been diagnosed with COPD for six years and had a smoking history of 20 pack years (a pack year equates to smoking 20 cigarettes per day for one year).

**Data analysis**

We recorded interviews digitally then transcribed them verbatim. Each transcript was read and reduced into manageable chunks using an open-coding scheme, which organised data into categories.

The data was analysed based on a “framework analysis” approach (Kreuger 1994); this uses a thematic approach, and also allows themes to develop both from research questions and narratives of research participants (Rabiee, 2004). Once we had identified organising themes, these were reported back to participants through a process of informal member checking. This involved verifying the researcher’s interpretations of the data with participants to ensure the validity of themes.

**Results**

Following data analysis, we identified four organising themes: causes; experiences; impact; and management of anxiety.

**Causes of anxiety**

Participants felt their feelings of anxiety were the result of disease-related worries. They were well informed about their disease and had interacted with others who had more advanced COPD.

Participants expressed their concerns about future disability, particularly on the possibility of needing regular supplementary oxygen. For many, the sudden impact of their COPD and the related deterioration left them feeling anxious about the future. One participant noted: “It has been very sudden and, to be honest with you, it is no good saying I am not worried about it because I am.”

For many participants, panic attacks were closely linked with breathing and they described this breathing-anxiety relationship as a vicious cycle. Episodes of panic were often preceded by breathlessness, which was worsened by subsequent feelings of panic. This cycle was often made worse because participants were confused between their symptoms of anxiety, breathlessness and the side-effects of medication.

For others, panic attacks were not related to breathlessness but were idio- pathic in nature. These events often occurred without warning, particularly when alone or in bed at night. Participants also described how they became anxious in relation to their medication. For some, being without what they deemed “lifesaving medication” was enough to trigger a panic attack. As one participant said: “It is a fear of being without medication that I think causes me panic attacks.”

**Experiences of anxiety**

Episodes of panic were the focus of participants’ recollections and were described in vivid detail.

They talked of a sensation of losing control during these episodes, which resulted in feelings of helplessness. They felt that panic had taken control of their body, yet they were fully aware of their predicament.