Research

Impact of anxiety

Participants generally felt that anxiety had a significant impact upon quality of life. Those who linked their anxiety to breathlessness found that avoiding potential breathlessness had a significant impact on their lives. They said they had become fearful of breathlessness as it was felt to be a precursor to a panic attack. Avoiding exercise was felt to be the only option, and this had an impact on their day-to-day lives.

“Cleaning windows, doing the gardening, exercising the dog, walking a distance or up a hill – it gets eroded bit by bit because of your fear of being breathless and being caught out and there being no help,” said one participant.

Having to constantly plan daily activities to avoid breathlessness was a source of frustration. Most participants felt they planned too much and that this limited their ability to participate in social and leisure activities. Planning was seen as a way of ensuring control over their lives, but they felt they worried needlessly about trivial things. In an attempt to avoid panic attacks by planning ahead, they experienced underlying worry about what may go wrong.

Participants also believed their anxiety affected family and friends. They felt it made them irritable and awkward to be around, and they also believed their panic attacks were distressing for their families to witness.

There was a general consensus that anxiety caused isolation. Some felt other people did not understand the impact that anxiety had upon them, while somatic symptoms, such as incontinence and sweating, made them feel embarrassed and made them avoid social situations. Some participants rarely left their homes and were effectively housebound.

Management of anxiety

Participants felt that failure to identify anxiety, particularly panic, was the most important barrier to effective management. Some said they had lived for years with anxiety but had not been aware of it. Sometimes they had confused their panic attacks with acute exacerbations of COPD, resulting in needless hospital admissions. They agreed that identifying episodes of anxiety was a challenge because of the overlap in the symptoms of anxiety and COPD, and the side-effects of medication.

Some participants said they had learnt to recognise the difference between anxiety and an exacerbation through self-management and close monitoring of their symptoms. Although they felt it took a period of adjustment to learn to recognise their anxiety, they agreed that health professionals played an important role in this. Nurses, community psychologists, GPs and physiotherapists were seen as playing a valuable role in helping participants to identify whether they were experiencing anxiety and, if so, how to manage their symptoms. In particular, community nurses had recognised that several participants may be experiencing anxiety and had changed their lives by providing support and education, and referring them for further help.

Rehabilitation was felt to be an important management strategy. Thirteen participants had done or were doing pulmonary rehabilitation and believed increasing their exercise tolerance had enabled them to tolerate increased levels of breathlessness and learn the difference between activity-induced breathing and anxiety-related breathing.

Participants described anxiety management strategies that they felt had enabled them to control their anxiety and to prevent episodes of panic. Breathing exercises were seen as particularly useful for panic, especially taking deep, slow breaths and regulating the rate of breathing.

Others found focusing was a successful strategy for managing panic. This appeared to be particularly useful in those whose panic was idiopathic and not caused by breathlessness from overexertion. Participants found they could control their panic by focusing on an object in the room or by counting.

Discussion

This study gives an insight into the challenges of living with COPD and comorbid anxiety. Participants recounted that anxiety, particularly in the form of panic, was an extremely unpleasant and potentially life-changing experience.

The causes of anxiety in people with COPD were closely linked to their respiratory disease. Alongside the expected disease-related worries, participants highlighted the link that exists between breathing and anxiety.

Through the narratives of people with late-stage COPD, Bailey (2005) found anxiety may be a sign of acute breathlessness rather than a result of it. These interviews indicate that, for some people with COPD, anxiety – particularly panic attacks – may be regarded as a sign of breathlessness, as Bailey proposed.

There also appears to be a group of people with COPD who experience panic attacks that begin spontaneously and are not necessarily triggered by breathlessness. These individuals appear to fit the more traditional view of panic, which has a sudden onset, with rapid breathing as a symptom (Bourne, 2005).

Nurses can play a vital role in identifying...