Plenary

Managing Breathlessness: the Breathing, Thinking Functioning approach

Speaker **Dr Anna Spathis** *Consultant in Palliative Care, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust*

Key learning points:

- Many patients continue to experience distressing breathlessness, even after optimisation of the underlying lung or heart condition.
- Chronic breathlessness can be inadvertently worsened by vicious cycles of emotional and behavioural responses.
- The Breathing, Thinking, Functioning clinical framework describes three predominant vicious cycles; it can facilitate symptom management by helping patients make sense of the symptom, and by suggesting the most relevant non-pharmacological management approaches.

What do we do when chronic breathlessness persists once we have looked for reversible causes, treated them and optimised the underlying disease?

This was the question Anna Spathis asked delegates at the beginning of her presentation.

"Breathlessness is a complex symptom. It is not only the subjective perception of breathlessness but the reactions and responses to the sensation that are important and that is a very key part of what I want to talk about," she said.

Breathlessness is extremely common and is likely to become more so with increasing ageing and multi-morbidity as so many underlying diseases are associated with the symptom.

People with breathlessness are two and a half times more likely to be admitted to hospital and account for one in five emergency department attendances.

It is also important to remember that breathlessness has a devastating impact on the carers of people with advanced respiratory disease, said Anna.

The Breathing Thinking Functioning (BTF) model, developed by Anna with colleagues, in the Breathlessness Intervention Service, explains how breathlessness perpetuates and worsens and provides a structure and rationale for its management.

It does this by engaging patients and professionals in turning the vicious cycles that can lead to breathlessness into 'cycles of improvement'. "The BTF model helps to make sense of breathlessness," she said.

The model is based on three predominant cognitive and behavioural reactions to breathlessness that, by causing vicious cycles, can maintain and worsen the symptom, irrespective of the underlying disease that triggered the breathlessness initially

The vicious cycles are:

- Breathing: Increased respiratory rate, inappropriate accessory muscle use and dynamic hyperinflation which can lead to inefficient breathing, and increased work of breathing
- Thinking: Attention to the sensation of breathlessness, memories of past experiences, misconceptions and thoughts about dying. This can lead to anxiety, feelings of panic, frustration, anger and low mood.
- Functioning: Reduced activity, social isolation and reliance on help which can lead to cardiovascular and muscular deconditioning.

Drug treatments are helpful for treating the underlying lung disease, but there is limited evidence for benefit in relieving the perception of breathlessness. Although non-drug treatments can be effective and safe, their use is hindered by lack of engagement with them, and by the challenge of choosing the most appropriate approach for individual patients out of the many approaches available.

The role of the BTF framework

- It can make sense of breathless: it can explain how breathlessness can be perpetuated, how things can get worse even when the initial trigger has settled, and how the symptom can become out of keeping with the severity of the underlying disease
- It offers motivation and mastery: it shows patients that there is always something that can be done to relieve their breathlessness, and that small changes which can lead to a big improvement by changing a vicious to a 'virtuous' cycle.
- It can provide a management focus: it can be helpful to start with non-pharmacological approaches that interrupt the predominant vicious cycle for an individual patient.

> "A fantastic conference - probably the best I have been to."

The assessment

When assessing patients Anna and her colleagues in the Breathlessness Intervention Service see patients generally between one and three times, with extra reviews by telephone if needed. "I spend a lot of time finding out what patients' existing coping strategies are - patients are experts in their own health. However it is important to manage expectations - I am upfront with patients that there is no magic wand to completely get rid of the breathlessness. However what we try to do is help people live as well as possible, so that they can get on and do the things that matter to them, without their breathlessness being a big feature in their lives."

During the consultation Anna assesses which of the BTF cycles are predominant and then using the BTF model discusses with patients how they can break their vicious cycles.

"At the beginning you are aiming for quick wins, things that work simply and reasonably fast, so you can engage patients in thinking 'I can do this'. It is really important that when talking to patients we avoid them feeling that it's their responses that have made the breathlessness worse.- I explain that their responses are normal – in fact it would be unusual for them not to occur."

Brief approaches that can be used:

Breathing cycle example:

Recovery breathing using a handheld fan. Encourage patients to use their fan and lean forward, to focus on breathing out for longer and longer with each breath out. and to gently relax and soften their shoulders each time they breathe out. Tell patients that by lengthening their out breath a little, they will be making space for the next breath.

Other non-pharmacological approaches: breathing techniques, airway clearance techniques, singing therapy

> "A very good and well organised conference. Lots of take home messages & ideas to put into practice."

Thinking cycle examples:

Consider using progressive muscular relaxation techniques, or suggesting patients use calming guided imagery such imagining blowing seeds away from a dandelion or sitting on a beach listening to waves. If patients do this at a regular time every day just for five minutes it can become second nature over time. "I sometimes suggest it's like taking a daily pill, but is safer and more effective,and patients really get that," said Anna.

Other non-pharmacological approaches: CBT, mindfulness and self-hypnosis

Functioning cycle example:

Exercise and activity: People with advanced respiratory disease can sometimes be sceptical about being told to 'exercise'. "I only ever talk to patients about 'doing the things they want to do' or encourage them to 'be a bit more active' at most. Quite a few people enjoy using a pedometer to count their steps, increasing them gradually week by week," said Anna.

Other non-pharmacological approaches: pulmonary rehabilitation, walking aids and pacing.

"The key thing about the Breathing, Thinking Functioning approach is that it is simply a structure, a framework, which can be used to cut through the complexity of breathlessness.

"Breathlessness clinics and interventions to manage breathlessness are gathering pace and given how debilitating this symptom is, we have great potential to make a difference not just to our patients but to their carers as well," said Anna.