# The Wounds We Don't Expect. PTSD in post cancer care

Dr. Marjorie A Docherty
FCFP
Clinical Professor Family Medicine.

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# Disclosures

- Dr. Marjorie Ann Docherty CCFP,FCFP.
- Department of Family Medicine UBC. SMP/UBC Residency-Faculty.
- No commercial conflicts.
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- Faculty for behavioural medicine Family Medicine Kelowna.
- Faculty undergraduate SMP/UBC, Rural family Medicine.

# Outline and objectives.

- Findings of literature review of PTSD in cancer care.
- To discuss how common PTSD is in cancer care.
- Overview of diagnosis.
- Overview of screening questions.
- Overview of management of PTSD.
- Discussion of post traumatic growth-.PTG and P-PTG

# PTSD – historical perspective - cur

Definitely a Dx now in vogue but not a new concept.

Homers Iliad- “ soldier horrors” [8th century BC.]

“Shell shock", "Battle fatigue” WW1- shame and disgrace.

Freud “ traumatic neurosis”

WW2 “ Battlefield neurosis”.

Holocaust Survivors, POW, War Vets.

# Current times

- We still have survivors of terror ,wars and conflicts
- We are starting to reflect on medical experiences.
- Post trauma care.
- ER
- ICU
- Cancer care.

# Incidence of PTSD

- Adverse lifespan events exposure- 60-70%
- Incidence PTSD 7-10% in lifespan
- General population prevalence 4-6%
- Female > male {2.5-1}
- Literature review suggests higher levels of PTSD and PTS than we realise related to cancer diagnosis, cancer treatment and prevalence of symptoms years after the treatment is completed.

# Some research stats;

- HNC mean 6 yrs post diagnosis
- 33% PTSS and 11.8% PTSD.

- Breast cancer pxs PTSD up to 33%
- {Younger women and more disfiguring surgery more at risk.}

- Prostate cancer pxs – FOR and anxiety 36% in pxs 7 yrs post completion of Rx for localized cancer.
- FOR. Related to decreased QoL, increases physical complaints, PTSS.

# Descriptors uses in research re cancer survivors

- PTSD – DSM 5 diagnostic categories
- PTSS – some of the symptoms persist and affect QOL.
- FOR – fear of recurrence is a significant stressor related to anxiety and at times depression ongoing post treatment.
- PTG – post traumatic growth
- P-PTG – physical post traumatic growth.
- AEE - ambivalence over emotional expression – increase PTSD risk.

# Seasons of survivorship

- Acute
- Transitional
- Extended
- Permanent
- Chronic – for many px diagnosis of cancer is a trauma that can span over many years or their existing lifetime – prolonged traumatic stress.
- Medical , psychological and socioeconomic needs in each stage may change and should be re evaluated.

# Post traumatic stress symptoms

Patients and family members both affected

2017 J.Clin Nursing, 347 pxs

Gynae, breast,colorectal ca – 21.6% pxs had high trauma scale scores, similar study identified high trauma scores in family members.

Painful memories

Insomnia

Feelings of shortened lifespan

Flashbacks

# Social support role- in PTSD/PTSS

- Family identification => strong predictors of PTS
- Sense of belonging- not just “ social supports”
- Commonality / communication with family ,members
- Family constraints- closed / judgemental – increased risk.
- Denial - closed to cancer discussions
- Lack of opportunity to discuss cancer related negative thoughts will adversely effect emotional regulation and recovery.

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# Increased risk PTSD /PTSS

- Female or young adults or adolescents
- Disfiguring surgery or extensive surgery
- Chemotherapy
- Radiotherapy
- Low baseline level of psychological or physical functioning.
- Baseline mental health or addiction issues

# Personality style and risk factors

- Extensive cancer –severity of disease.
- Extensive treatments.
- Immature defence style of emotional coping
- Emotionally unmet needs at baseline – or emotional numbing.
- Denial – lack of meaningful engagement.
- Avoidant behaviour - AEE
- Negative affect – baseline anxiety

# Acute – PTSD

# DSM V- clusters of symptoms

1.Event;

Direct/ witness / learn from others / repeated exposure

In cancer care this can be a continuum of many years.

2. Intrusion or re experiencing {2}

images, dreams, thoughts, illusions, hallucinations, dissociation,

Flashbacks, cues causing intense psychological distress.

# DSM V- clusters of symptoms

3.Avoidance {1}

Thoughts, feelings, conversations. Places, people, activities.

4. Negative cognition and mood {1}

Memory, beliefs, cognition distorted, neg emotional states, decreased interest , detachment, estrangement , cant experience positive emotions.

5.Hyperarousal symptoms {1}

Irritable, angry, reckless self destructive. Hyper vigilance, poor concentration, sleep disturbance.

# DSM –V diagnostic criteria

6.More than once per month

7. Significant distress or impairment.

8. symptoms not due to substance abuse. { may be using SUD to self medicate symptoms}.

# General PTSD risk factors

- PH physical , sexual or mental abuse other FOO issues
- PH torture
- PH - PTSD, anxiety, depression,
- Substance abuse
- ? Family history PTSD .
- Baseline personality issue –axis 2 dx
- Lack of social/family supports
- ? Low emotional IQ, ability to emotionally express.

# Increased risk PTSD /PTSS

- Persistent post RX somatic symptoms
- Loss of sexual function or feelings
- Body change stress
- Negative cognitive perceptions of illness – shame and blame.
- Cognitive changes , fatigue post treatment [ 33% breast ca pxs 5 yrs post dx]
- Early treatment changes in mood and QoL may predict PTSD.

# Altered life trajectories with untreated PTSD

- Disables intimacy
- Increased social difficulties
- Feel isolated, disconnected and different from others
- Increased work place difficulty and conflicts
- Increased risk taking and decreased self care
- Increased relationship discord and divorce
- Significant psychosocial and often medical cost.

# In the consultation;

- May dissociate or freeze in exams or procedures.
- May remember little of what you told them especially in high stakes conversations.
- May use defensive humour.
- May belittle their issues.
- Increased risk > depression x5 ,anxiety x 5-10, Panic x 3-20,

Somatization is increased up to x 90 in incidence in untreated PTSD-hyperawareness or symptoms and body checking.

# Tools for dx

- PTSD check list civilian version -17 item score sheet
- GAD
- PHQ 9
- And others for depression and anxiety eg. HDS.
- Review illness related burden for px – what else is going on in their life.

# Physiological changes

- Brain nuclei – neuro anatomical
- Neuro hormonal – eg. decreased serotonin uptake.
- Physiological – especially adrenocortical hormones.
- BP and HR.
- Increased startle response.
- Sleep disruptions.

# Psychological treatment

- Help them find their coping mechanisms
- Check they are safe – check for suicidal intent
- Help them have choices and give back some sense of control
- Collaborate on care
- Avoid avoidance of the issues
- Evidence shows some success for mindfulness based programs or CBT or DBT type therapy.
- Early screening and implementation of psychological health and physical health strategies seems to positively effect outcomes.

# Relationships

- Don’t forget the family relationships.

- Your relationship with the patient is a treatment
- Consistency in care giver relationship is important.


WE DO NOT HAVE WIFI
TALK TO EACH OTHER!

# Role of resilience

- Baseline Resilience; this is a personal attribute and the ability to bounce back.
- Self esteem
- Mastery
- Optimism
- Better resilience scores decrease risk of PTSD and PTSS and depressive risk. Decreased ruminative search for “meaning of illness” and increase positive feelings of life purpose.
- Improved psychological adjustment to illness and decreased maladaptive meaning making.

# Post traumatic growth

- Patient experiences a traumatic event that challenges their core beliefs or physical health and they have difficulty bouncing back. They endure psychological struggle [+/- illness like PTSD or depression] and ultimately find a sense of personal growth and discovery.
- More likely when they demonstrate openness.
- Outgoing personality.
- Cognitive capacity.

# Post traumatic growth - PTG

- Increased knowledge and understanding of survivors cognitive perception of illness and perceived threats both physical and psychological may allow care providers to have better psychosocial understanding of the patient and help collaborate on PTG.
- Management of increased anxiety and mood changes - important to recognize and deal with this early in treatment.
- Recognize social, ethnic, racial , financial barriers to PTG.
- Tedeschi and Calhouns functional descriptive model of PTG 1996, 2004 lead to research by many others into PTG determinants.

# PTG- 5 categories , 21 items

1.Relating to others;

count on others, sense of closeness, willing to express emotions, compassion, effort into relationships, seeing people as wonderful, accepting need for help.

2.New possibilities;

new interests, new life path, doing better things with life, seeing new opportunities, change where needed in life

# PTG- 5 categories , 21 items

3.Personal strength;

feeling of self resilience, I can handle difficulties, acceptance of how things work out, discover inner strength.

4.Spiritual change;

better understanding of spiritual matters, stronger faith.

5.Appreciation of life;

priorities about what is important, appreciation for value of own life , appreciating each day.

# Physical PTG

- Physical post traumatic growth was related in studies to better adjustment to diagnosis and treatment , increased resilience , and improved long term quality of life.
- Early intervention with physiotherapy , trainers , kinesiologists,

Dieticians , referral to yoga and pilates instructors etc

Continuing to work contributes to positive PTG.

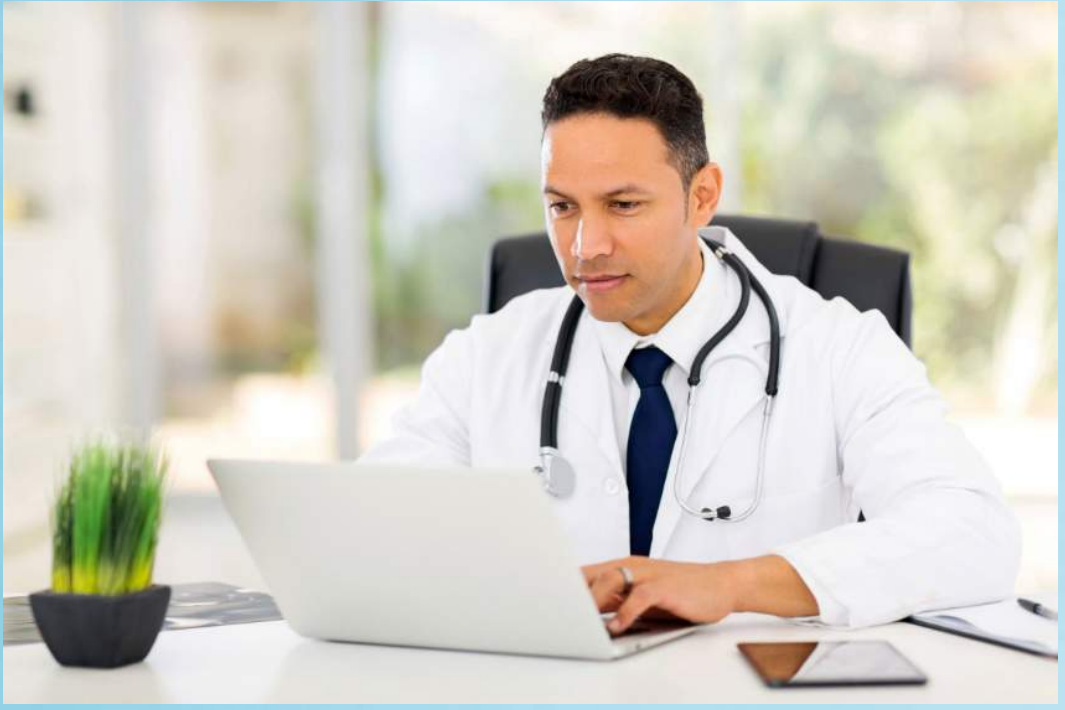
Allows enhanced appreciation of body , increased self confidence and sense of self, increased healthy attention to body function. Healthy behavior changes. Improves body function and overall strength. Mental health benefits of exercise and diet.

# PTSD – consequences of lack of awareness

- Misinterpret px behaviour
- Misdiagnose symptoms – what the tongue cant tell the body will express.
- Over investigate and unnecessary interventions and treatments.
- Prolonged mental suffering, decreased quality of survival
- 45% pxs in Ca support study 2006 said the emotional effects worse than physical
- Loss of caregiver – patient trust and relationship- you cant see or hear me.

# Management PTSD - PTSS

- Ask the questions and make the diagnosis
- Their story and perceptions
- Clarify information understanding
- Treat mood disorders
- Address substance abuse
- Consider physical health determinants that can be improved
- Encourage full functioning within their abilities



Challenges

Time for care

EMRs – boxes and ticks

Loss of face to face and body language loss.

# Medication in PTSD

- SRI, SNRI- re-experiencing , numbing, hyperarousal, avoidance.
- Clonidine – sleep and nightmares
- Mirtazepine – insomnia , REM sleep
- Trazodone – insomnia / REM restoration
- B Blockade – anxiety, tachycardia , hyper arousal – short term
- Anticonvulsants – carbamazepine, lamotrigine, decrease impulsivity and emotional lability
- Always consider chemo drug interactions but balance with need vs theory.

# Coping skills programs

- One study – virtual environment . Manual , instructor.
- Demonstrated decreased rates of ;
- Depression , anxiety
- PTSD
- Fatigue
- Increased wellbeing.
- Others strategies focused on appearance , self esteem education and physical fitness coaching – all similar outcomes.

# Mindfulness – MB-Stress Reduction

- Helps cognitive reprocessing, non judgemental acceptance, kindness and openness.
- Increases awareness of self and world around
- Increases healthy body awareness and self care
- Assists in relating to others
- Living life experientially in the moment
- Higher levels of mindfulness are related to less anxiety, less distress, better quality of life and more post traumatic growth.

# Mindfulness, resilience , emotional learning

# MBSR

- Teaching body scan
- Breathing space
- Sitting meditation
- Walking meditation
- Mindful movement
- Daily home practices

Research shows > better mood and sleep, less fatigue, improved coping, better psychological adjustment

# Overall evidence of PTSD/PTSS in cancer care

- Risk factors are identifiable.
- PTG can be positively influenced by care giver patient alliance, awareness of patients psychosocial issues and holistic patient centred care.
- Mindfulness and CBT type strategies can be effective in increasing QoL and decreasing distress
- P-PTG can be encouraged and supported and also increases QoL outcomes.
- Psychological interventions should play an integral part of the care and assessment of cancer patients

# Overall evidence of PTSD/PTSS in cancer care

- If you don't ask they likely will not tell you.
- Medical targeted cancer treatment is only part of the picture.
- Not dealing with psychological trauma does adversely affect clinical outcomes and quality of life for survivors.
- The prevalence of PTSD/PTSS is much higher than we think.

Thank you