Oncology nursing role in cancer-related PTSD—Part II

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**ABSTRACT**

Cancer-related posttraumatic stress disorder (CR-PTSD) is relatively newly defined, lacks clinician awareness and, therefore, often goes undiagnosed. Untreated CR-PTSD can be debilitating; negatively impacting all aspects of a patient’s life throughout diagnosis, treatment, and into survivorship. Oncology nurses’ frontline role, which includes caring for both patients’ physical and psychosocial needs, and commonly forming a trusting relationship with patients, makes them ideal candidates for providing emotional support and assessing patients for risk or symptoms of CR-PTSD. In addition to a brief summary on the current nursing role in assessing and treating psychiatric ailments such as cancer-related PTSD (CR-PTSD), and recommendations about how nurses can be involved in assessing patients for CR-PTSD and provide psychosocial support to these patients. Oncology nurses have many different responsibilities, such as conducting intake assessments, which includes obtaining medical and personal histories (i.e., history of depression) and assessing patients’ knowledge of their disease, ability to provide self-care, and support systems in place. A major oncology nursing role is communication, which includes responding to patient concerns in clinic and via nursing phone lines. When possible, oncology nurses can use these opportunities to support resilience and relieve emotional, practical, and social distress in patients by ensuring rapid response and facilitating access to extra services when necessary. Nurses can provide patients with information about resources and supports available to them and their family members, including return to work groups, disability advice, and psychology and social work services (including drug reimbursement specialists), which can all help to decrease patients’ overall levels of distress.

In some hospitals, oncology nurses are involved in screening patients for specific disorders that may interrupt treatment, including cancer-related PTSD, using validated screening measures (Pirl et al., 2014). Psychiatric nurses are trained to address the psychological needs of their patients and have expressed feeling as though they act as both nurse and therapist (Arving & Holmström, 2011). Unfortunately, oncology nurses have expressed concerns regarding both a sense of uncertainty in their roles and responsibilities in psychosocial care, and often feeling inadequately prepared to assess patients for PTSD (Arving & Holmström, 2011; Hejri-Rad et al., 2019). An important step in being able to properly address the psychosocial needs of oncology patients would be identifying patients in need of emotional support, including those who are at risk of developing cancer-related PTSD.

**IDENTIFYING VULNERABLE (AT RISK) PATIENTS**

Certain risk factors for developing PTSD, including young age (Abbey et al., 2015), can be easily identified, whereas characteristics and behavioural changes are more difficult to recognize (Ellis and Zaretzky, 2018). Through conversations with patients and their loved ones, nurses can identify baseline characteristics and symptoms post-diagnosis that may be indicative of unusual psychological distress (Molina et al., 2014).

According to a systematic review on personality traits and PTSD, one trait that is common in stress-prone personalities and has been correlated with PTSD in numerous studies is neuroticism (Jaksic et al., 2012). Neuroticism can be described as a tendency to have rapid and strong emotional reactions to adverse events (Jaksic et al., 2012). In fewer cases, low levels of agreeableness (the tendency to be pleasant in social situations) and high levels of psychoticism (characterized by anger, irresponsibility, and impulsiveness) were also correlated with PTSD (Jaksic et al., 2012). In addition to those with stress-prone personalities, patients with prior mood and substance use or dependence disorders (Shelby, Golden-Kreutz & Andersen, 2008), negative affect (Shand, Cowlishaw, Brooker, Burney, & Ricciardelli, 2015), and those who are less assertive (Arnaboldi, 2017) may also be particularly vulnerable to developing cancer-related PTSD. Less assertive people may be vulnerable to developing cancer-related PTSD, as they may feel powerless and are less likely to voice their concerns to health care providers.
or ask for help to better manage distress.

The diagnostic period is a time of elevated distress and heightened anxiety (Brocken, Prins, Dekhuijzen, & van der Heijden, 2012). Therefore, those experiencing prolonged wait times between diagnostic testing and results may be especially vulnerable to developing cancer-related PTSD. Special attention should be given to those patients who express anger towards or take out frustration on the healthcare system, as these may be signs of intolerable levels of anxiety. Lastly, surgical oncology patients who experience post-operative delirium have been shown to be more likely to suffer from PTSD at three months post-op, especially in those who feared the threat of loss of life or cognitive decline post-surgery (Drews et al., 2015).

In addition to identifying patients who are at higher risk for developing PTSD, nurses should be trained to identify clinical signs of PTSD in their patients (Table 1). Some patients may display strong negative emotions, withdraw socially, avoid stressful situations (including necessary procedures or investigations), interpret stressful situations as overly negative (i.e., clinical interactions), and display higher intensity negative reactions in the course of clinical care. Maladaptive coping may manifest as excessive rumination, such as severe indecisiveness due to fear of making the wrong treatment decision; excessive rumination, in turn, may lead to depression (Abela, 2002). Maladaptive coping can also include displacement, such as rejecting conventional treatments for alternative treatments after previously watching a loved one suffer the side effects of conventional treatments.

### ASSESSING PATIENTS FOR CANCER-RELATED PTSD

A study by Knobf et al. (2014) revealed that nurse-led implementation of psychosocial distress screening is feasible. General anxiety screening tools such as the Generalized Anxiety Disorder-7 (GAD-7) (Spitzer, Kroenke, Williams, & Lowe, 2006) or the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) would likely yield above cut-off scores in someone with posttraumatic stress symptoms, which would alert nursing staff to engage in conversations with patients and screen further. Patients who are suspected of suffering from PTSD should be assessed using validated tools, like the Post Traumatic Symptom Scale 10 (PTSS-10) (Stoll et al., 1999) or the Posttraumatic CheckList - Civilian Version (PCL-C) (Ruggiero, Del Ben, Scotti, & Rabalais, 2013).

### NURSING INTERVENTIONS

Since patients see their nurses on recurrent visits throughout diagnosis and treatment, they often come to feel that their nurses genuinely care about them and are more likely to voice concerns to their nurses, especially when approached with a calm and open manner, a sense of concern and time for their worries (Bruce et al., 2018). This allows the opportunity for nurses to be more involved in psychosocial assessment and intervention than current routine practice.

While posttraumatic stress has been associated with negative affect, posttraumatic growth has been associated with optimism, spirituality and positive coping styles (Shand et al., 2015). Helping patients to learn positive coping skills and reduce maladaptive coping can, in turn, help patients handle ongoing stressors during and post treatment. One example would be to help patients correct negative thinking by gradually replacing negative thoughts such as, “I am worthless and a burden,” with more positive thoughts such as, “I am lucky that I have a supportive family by my side,” and, “I would do the same for them.” Additionally, nurses can help to promote resilience by regularly checking in with patients, encouraging optimism (Shand et al., 2015), instilling a sense of hope (Vartak, 2015), promoting connection with friends/family (Vartak, 2015), promoting feelings of calmness and safety, and encouraging patients to be actively involved in their treatment. Oncology nurses can learn focused therapeutic communication skills to acknowledge and validate any feelings or concerns that patients may have (Ercolano, 2017). Nurses can also become skilled in teaching deep breathing and meditation exercises, as multiple studies have revealed psychosocial benefits using various forms of these techniques in patients with cancer (Ledesma & Kumano, 2009; Offidani, Peterson, Loizzo, Moore, & Charlson, 2017; Dhruva et al., 2012).

Educating patients and their families about common reactions to traumatic events and normalizing symptoms of distress can be beneficial in preventing the exacerbation of distress and anxiety. When necessary, nurses can facilitate referrals to psychiatrists or psychologists with specialist training in trauma and PTSD who can offer cognitive behavioural therapy for patients who need additional assistance to reduce avoidance behaviours, and offer medications recommended for PTSD and associated sleep issues, such as recurrent nightmares. Discussing the benefits of seeking professional help to deal with psychosocial distress may help to reduce its associated stigma.

<table>
<thead>
<tr>
<th>Table 1: Clinical signs of PTSD in patients with cancer</th>
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<tbody>
<tr>
<td>• Chaotic behaviour</td>
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<td>• Agitation</td>
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<td>• Inability to take in information (i.e., asking the same question over and over)</td>
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<tr>
<td>• Higher than usual distress (i.e., fearful/anxious about any and all side effects)</td>
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<tr>
<td>• Extreme worry and rumination over illness-related decisions</td>
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<td>• Extreme anxiety about any type of procedure</td>
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<td>• Trying to 'become an oncologist' by spending a lot of time researching their condition</td>
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<tr>
<td>• Avoidance of scans, investigations, treatments</td>
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<tr>
<td>• Insomnia</td>
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<tr>
<td>• Under-engagement or seemingly numb (i.e., too quiet)</td>
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<td>• Missing appointments</td>
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<td>• Frequently late for appointments</td>
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<tr>
<td>• Increased levels of cortisol and catecholamines in urine (Arnaboldi, 2017)</td>
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Despite the centrality of the nursing role in oncology, and opportunities for oncology nurses to identify and assist patients suffering from cancer-related PTSD, barriers do exist. One such barrier is that patient-nurse interactions are often extremely limited due to competition for patient time with other health care providers; including oncology residents, speech pathologists, nutritionists and social workers. One solution would be to promote quality patient-nurse time to allow for meaningful response to distress by establishing nurse-led clinics for patients with complex emotional and physical needs. Additionally, counseling training and augmentation of the role of nursing phone lines to allow quality time for nurses to respond to patient concerns could increase the clinical impact of oncology nurses in identifying, assessing and managing distress, including PTSD.

**PROTECTING ONCOLOGY NURSES**

Although oncology nurses may be in an ideal position to be involved in their patients’ psychosocial care, including screening and intervention for cancer-related PTSD, it is important that nurses prioritize their own well-being to avoid psychological harm. There is a wealth of literature regarding compassion fatigue and burnout in health care providers, as the helping nature of their relationships with patients can result in a heavy psychological burden, which can lead disorders such as depression and anxiety (Figley, 1995; Wu et al., 2017; Adams, Boscarno, & Figley, 2006). Compassion fatigue is the emotional burden felt by individuals constantly helping those in severe distress (Figley, 1995; Wu et al., 2017) and often contributes to burnout, which is a response to chronic emotional job-related stress (Maslach, Schaufeli, & Leiter, 2001). The interpersonal demand on nurses can be increased with increased workloads, ongoing contact with patients who are suffering, and client acuity and complexity (Sabo, 2008). This burden is compounded when combined with a lack of experience, appropriate skills, and professional or social support (Sabo, 2008). Therefore, if oncology nurses are to be responsible for screening and intervening with psychosocial distress, it is imperative that hospitals provide proper education, training and support resources for their staff.

**CONCLUSION**

Untreated cancer-related PTSD can negatively impact investigations, treatment course, recovery, quality of life, ability to return to work and family life (Chen, Hsu, Felix, Garst, & Yoshizaki, 2017; Caruso, Nanni, Riba, Sabato, & Grassi, 2017; Gold et al., 2012). Despite the known risk factors and warning signs to identify vulnerable or symptomatic patients (Abbey et al., 2015; Swartzman, Booth, Munro, & Sani, 2017; Cordova et al., 1995; Li et al., 2017), cancer-related PTSD is still often missed. Oncology nurses should be trained to properly identify and assess the clinical signs and symptoms of PTSD, know how to screen for it, and be able to provide patients with education materials and primary level intervention and monitoring, as well as access to specialized consultation or referrals. Their relationships with patients and frontline role make oncology nurses ideal candidates to assist in decreasing the prevalence of unidentified and untreated cancer-related PTSD.

**REFERENCES**


