

AUTHOR'S REPLY

Deconstructing the complexity of PTSD in cancer

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We would like to thank Richard Fielding and Wendy W. T. Lam for their correspondence on our News & Views article (Post-traumatic stress disorder—prevalent and persistent. *Nat. Rev. Clin. Oncol.* 10, 252–254; 2013),¹ which raised some important issues (PTSD—more complicated on second look. *Nat. Rev. Clin. Oncol.* 18 June 2013; doi:10.1038/nrclinonc.2013.49-c1).² We would like to address several points regarding their call for recognizing the complexities of post-traumatic stress disorder (PTSD) in patients with cancer. Of course, PTSD in medically ill patients is a complex topic because there are likely to be subgroups of distress responses that occur at different points. Unfortunately, Fielding and Lam misinterpreted our views on this matter—we also recognize such complexities. Hopefully, this exchange can stimulate a productive discussion with our colleagues in Hong Kong and beyond.

One of the concerns raised by Fielding and Lam was the use of the Impact of Events Scale (IES) to assess PTSD in the study by *vin-Raviv et al.*³ about which we wrote our News & Views. We regard the IES as a legitimate measure of PTSD symptoms, and not a measure of general distress, because the IES measures two of the three symptom clusters of PTSD—avoidance and intrusion. On one hand, Fielding and Lam² correctly note that hyperarousal symptoms were not assessed by the IES in studies by *Vin-Raviv et al.*³ and others. On the other hand, women reporting frequent experiences of avoidance and intrusion symptoms associated with their cancer should raise concern among clinicians caring for these women.^{4,5}

We do not agree that it is “far too gross a generalization” to conduct preliminary research using the term ‘Asian’ in the context of a clinic-based research sample drawn in the USA, where large numbers of people from specific Asian countries are generally insufficiently represented to enable subgroup analyses. We look forward to reading Fielding and Lam’s

article when it is published on the cultural and individual differences in supportive care needs during cancer. [Editor’s note: since the time of writing, the article in question has been published. See: Attributing variance in supportive care needs during cancer: culture-service and individual differences before clinical factors. *PLoS ONE* 8, e65099 (2013).] Within the context of a ‘melting pot’ such as the USA, comparing Asian patients with patients of other racial or ethnic backgrounds can be a starting point to understand the cultural differences in patients’ needs for supportive care. At the same time, we agree that examining subgroup differences—such as country of origin or residence—is better than leaving these factors out of the analyses when the data allow for such comparisons. We also concur that the lack of differentiation should be kept in mind when categorizing subgroups within the term Asian. As research progresses, subgroup cultural differences should become considerably more nuanced to understand the needs for supportive care in patients with cancer. For example, when considering ethnic differences among immigrants, the degree of acculturation is also relevant.⁶

We would like to move away from debating the complexity of screening and diagnosing PTSD and instead draw further attention to the importance of identifying the important minority of women with breast cancer whose trauma symptoms seem to be considerable enough that further evaluation is warranted. Fielding and Lam² did not discuss the high societal and personal burdens associated with untreated PTSD symptoms among women whose symptom course is neither mild nor transient. As we previously noted,¹ many patients living with PTSD experience worse health outcomes than those without PTSD via multiple pathways that can lead to greater morbidity and shorter survival.^{7,8} Thus, the costs of screening, evaluating and treating PTSD (when warranted) must be weighed against the alleviation

of the societal and personal burdens of untreated PTSD.

Of course, we agree with Fielding and Lam² that not all women with breast cancer who screen positive for PTSD symptoms require treatment. However, when screening procedures are not in place, women with clinically significant levels of distress would likely be missed. That is, the risks associated with overtreating PTSD must be balanced with the risks of undertreatment. To address Fielding and Lam’s question about who should be treated and when, focusing on women who are most disabled by their symptoms seems most sensible.⁹ This approach would require that the symptoms be screened for in the first place and that impairment in social, occupational or other important areas of functioning also be investigated. A screening measure for PTSD can be brief, such as the seven-item screening scale of Breslau *et al.*¹⁰ that has been demonstrated as having strong reliability and validity when used to assess PTSD in the primary care setting.¹¹ The implications of our commentary on the study by *vin-Raviv et al.*³ would not necessitate constant screening across all women with breast cancer. Instead, we think that improving the screening at any problematic junction—such as following diagnosis, during treatment or at the end of treatment—could identify women who would benefit from further evaluation.

In the field of psychiatry, we do not create symptoms but rather respond to patients’ accounts of their experiences and treatment needs. In using a diagnosis drawn from psychiatry, the goal is not to pathologize; understanding and addressing patients’ existing needs is the focus. However, until science progresses, we can only use existing tools to help our patients, keeping in mind the need to identify better constructs. Although PTSD research resources are continually evolving, women with breast cancer are already here, and many could benefit from the application of the best-available knowledge and tools.

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Competing interests

The authors declare no competing interests.

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