FEAR OF RECURRENCE

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COMPLETION OF TREATMENT

Often anticipated as being the time to breathe again and reclaim life

But the reality is:

- **Facing a "new normal" and adjustment in terms of goals and expectations**
- **Abrupt disconnection from the treatment team**
- **Evaporation of practical and emotional support**
- **Lack of clarity about the goals of follow-up**
- **Disconnection from those who aren't members of "the club"**
- **Tempered by social expectations and pressure to conform/"think positive"**

FEAR OF CANCER RECURRENCE

"The fear that cancer could return or progress in the same place or another part of the body" ***Vickberg 2003***

Transient FCR almost invariable, however:

- **40 to 70% of cancer survivors report *clinically significant* FCR** ***Thewes et al 2009***
- **FCR identified as one of the greatest unmet needs of cancer survivors** ***Hodgkinson et al 2007***

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High FCR associated with:

- ❑ **Greater distress & poorer QOL**
- ❑ **Lack of planning for the future**
- ❑ **Avoidance of, or excessive screening**
- ❑ **Greater health care utilisation**

FCR AND HEALTH PROFESSIONALS

Survey of 76 psycho-oncology health professionals

47 oncologists and nurses

- **30% reported FCR was an issue for more than half their patients**
- **31% of doctors reported spending more than 25% of the time in follow-up consultations discussing FCR**
- **46% found dealing with FCR challenging**
- **71% were interested in further training in how to manage FCR** ***PoCoG 2010***

TRADITIONAL APPROACHES TO DISTRESS

Cognitive behaviour therapy:

Aims to:

- Help identify unhelpful thoughts and behaviours
- Develop skills to challenge cognitive distortions, selective abstraction etc.

Fails to:

- Acknowledge the clinical reality and uncertainty about prognosis
- Help the person understand the origins of maladaptive patterns of thinking and behaving
- Help the person respond to existential challenges

A NOVEL INTERVENTION

This intervention addresses core themes pertinent to the person who has experienced cancer

Aim of this intervention is not to get rid of worries about recurrence completely:

- ✓ **To help people with high FCR to assign less importance and less attention to this concern**
- ✓ **To develop goals for the future which will give their life purpose, meaning and direction**

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THEORETICAL FRAMEWORK

Self-regulatory Executive Function model identifies several inter-related components of cognition linked to the development and maintenance of emotional disorder ***Wells and Matthews 1994***

Cognitive attentional syndrome (CAS)

- **Self-focused attention**
- **Worry and rumination**
- **Attentional bias towards threat-related information**
- **Coping behaviours that are maladaptive (e.g. suppression, avoidance, minimisation) because they impair flexible self control or prevent corrective learning experiences**

PILOT STUDY RESULTS

Demographic details	n (%)
Gender (Female)	8 (100%)
Relationship status ▪ Married/defacto ▪ Divorced/separated	 6 (75%) 2 (25%)
Educational attainment ▪ High School ▪ TAFE/University	 5 (62%) 3 (38%)
Employment ▪ Employed ▪ Retired/pensioner	 7 (88%) 1 (12%)
Country of birth Australia	 6 (75%)
Children Yes	 7 (88%)

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	Mean (range)
Age at diagnosis (years)	49 (37 – 64)
Time since diagnosis (years)	2.3 (0.8 – 4.5)
Disease & treatment details	**n (%)**
Cancer type ▪ Breast ▪ CNS lymphoma ▪ Hodgkin's lymphoma ▪ Endometrial/kidney cancer	 5 (64%) 1 (12%) 1 (12%) 1 (12%)
Treatment ▪ Surgery ▪ Chemotherapy ▪ Radiotherapy ▪ Hormone Therapy ▪ Herceptin	 7 (88%) 8 (100%) 6 (75%) 3 (38%) 3 (38%)
Currently receiving hormone treatment	3 (38%)

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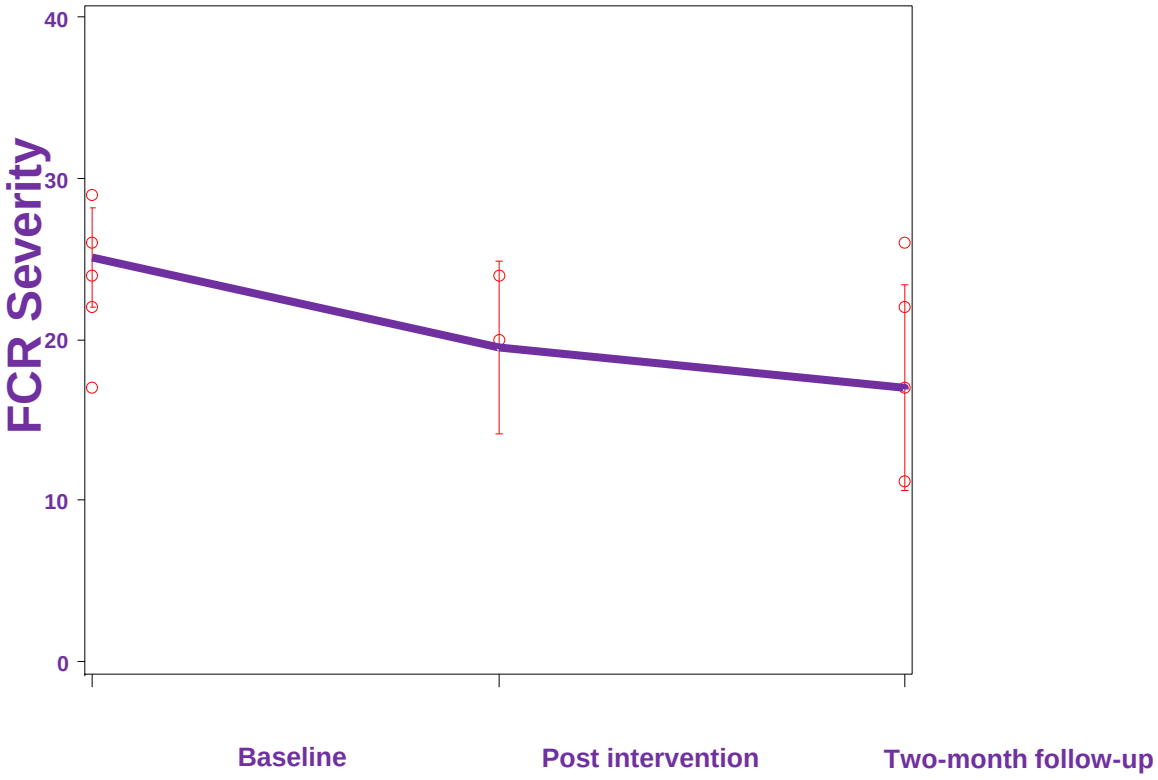
FCR SEVERITY



↓ of 8.2 points on the 36-point Fear of Cancer Recurrence Inventory (FCRI) Severity Subscale; p = 0.002, effect-size 1.9

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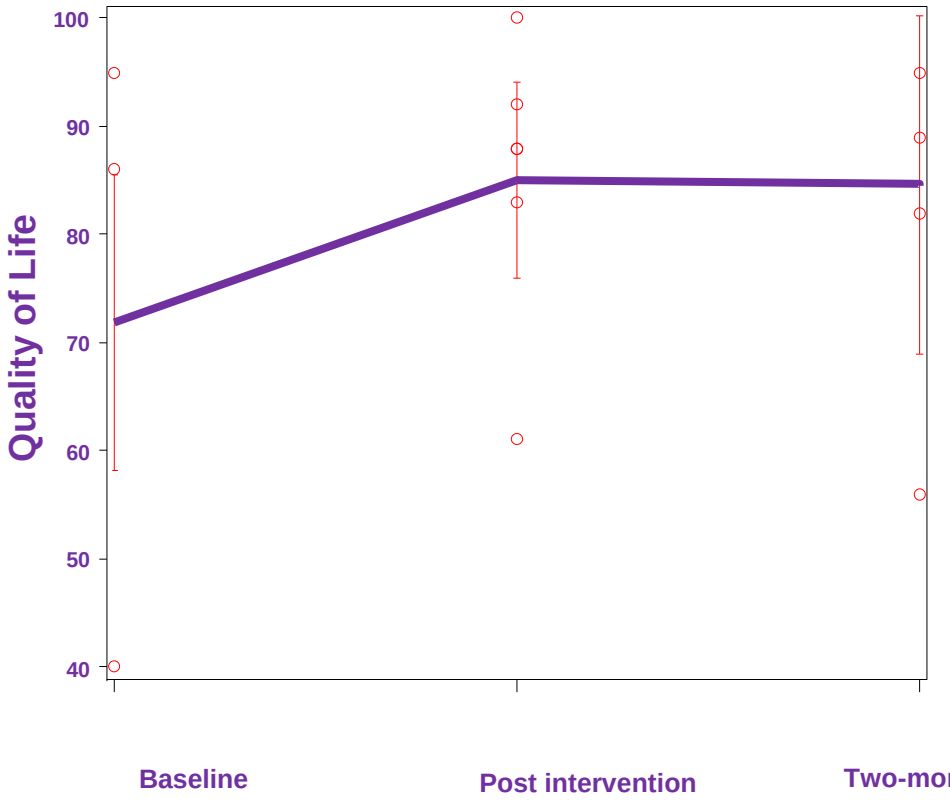
QUALITY OF LIFE



↑ of 13.0 points on the 100-point FACT-G; p = 0.2, effect-size 0.67

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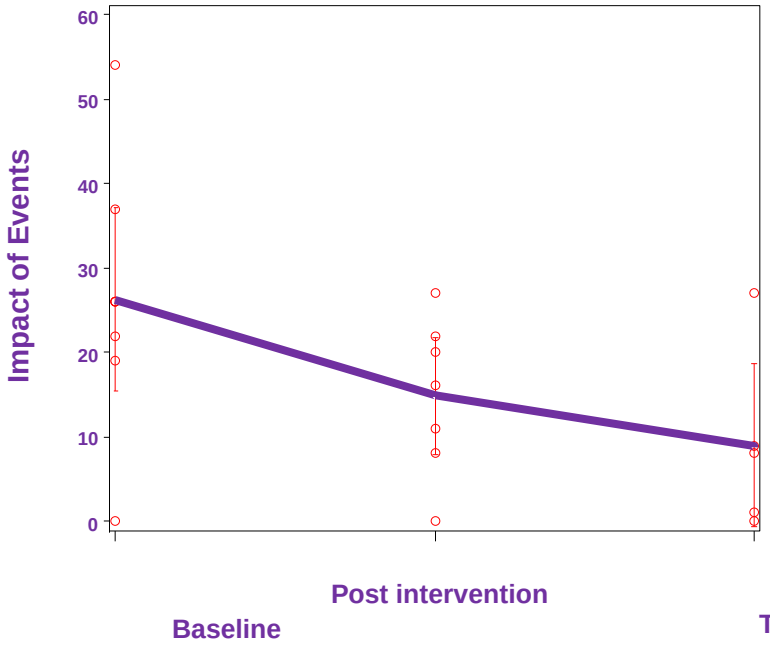
DISTRESS



↓of 17.7 points on the 75-point IES;
p = 0.03, effect-size 1.2

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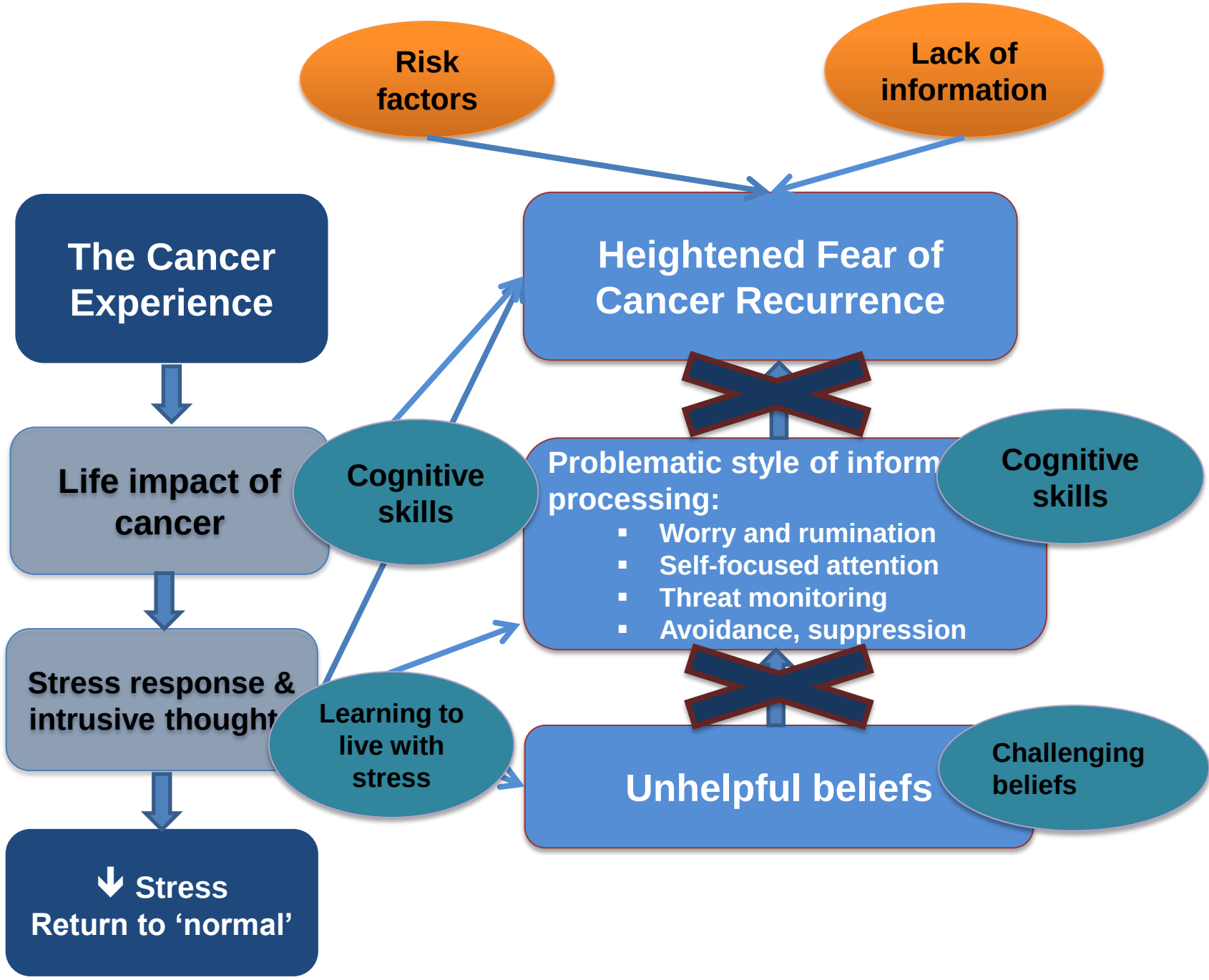

Risk factors
Lack of information
The Cancer Experience
Heightened Fear of Cancer Recurrence
Life impact of cancer
Cognitive skills
Problematic style of inform processing:
Worry and rumination
Self-focused attention
Threat monitoring
Avoidance, suppression
Cognitive skills
Stress response & intrusive thought
Learning to live with stress
Unhelpful beliefs
Challenging beliefs
Stress
Return to 'normal'

SOME CORE COMPONENTS

Aim of DM in MCT is to:

- ❑ **Teach patients a new way of relating to their thoughts**
- ❑ **Develop a sense of objectivity or detachment from thoughts (self as separate from our thoughts, observer)**
- ❑ **Develop awareness (meta-awareness) of thoughts**
- ❑ **Without being locked-in to thought (suspension of conceptual processing, evaluation, engagement)**

Aim of DM is to be able to:

- ✓ **Have a thought**
- ✓ **Be aware of it**
- ✓ **Do nothing about it (not engage with it)**

A *"do-nothing strategy"* (Wells)

Can be used in conjunction with worry postponement skills

ATTENTION TRAINING

In ATT thoughts or inner experiences which intrude into conscious are viewed as 'noise':

- **ATT aims to give people greater control over directing their attention away from that 'noise' to focus elsewhere**

Choosing to focus elsewhere does *not* mean the person is not aware of their thoughts & inner experiences

ATT is not intended to create a "blank mind"

In fact, thought suppression has the opposite effect: "Pink elephant"

THREAT MONITORING

Threat monitoring (TM) is necessary to identify & manage danger

e.g. without it we would all walk off the curb under a bus, nothing would warn us of the danger & pull us back

Key points:

- **Many people who had had cancer become oversensitive to danger cues**
- **This makes some people check more for them (TM) & some people avoid them**
- **Research has shown that neither of these techniques is particularly useful**
- **Uncertainty is a normal part of life – the aim is to live with it**
- **One technique is developing "body awareness"**
  - **This involves checking as often as recommended, knowing changes to be aware of & changing lifestyle factors**

“NOT A CLEAN SLATE”

Few people come to a diagnosis of cancer without past experiences of loss or adversity

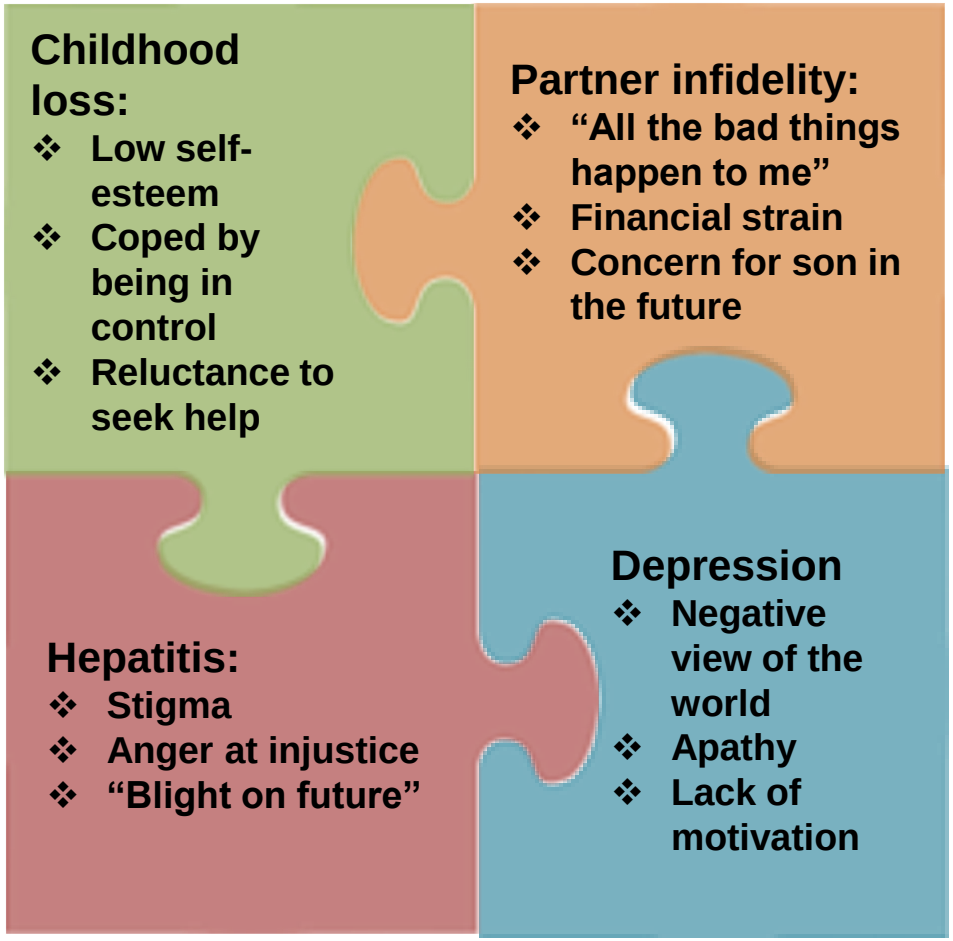
For many, this has shaped their world view

In response to reassurance or being urged to “be positive”, many people feel guilty or ashamed that they are not “over it”

A formulation allows the person to see the origins of their fears

Not a therapy of itself but can be affirming

UNDERSTANDING VULNERABILITY



ATTENTION TO VALUES AND GOALS

What matters to me?

What do I want for my future?

Where do I currently focus my energy?

What could I do to achieve my goals?

Taking an active role in planning and contemplating the future vs. being a “passive recipient of life”

INFORMATION AND CORRECTION OF MISPERCEPTIONS

Information about risk may be difficult to interpret

Goals of follow-up may not be clear to patients

Importance of moving beyond surveillance to promotion of wellness

Contribution of lifestyle factors

Prevention of other health problems

Stress is part of life!

IN SUMMARY

Fear of recurrence poses a considerable burden for patients and health professionals

Traditional interventions fail to address key issues

Emerging conceptualisations offer promise

Take home messages:

- **BEWARE REASSURANCE**
- **Beware doing extra tests "just to reassure her"**
- **Need to have a repertoire of explanations e.g unwelcome passenger**
- **Tolerating distress vs. having to fix it**

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