FAST FACTS AND CONCEPTS #398
ASSESSMENT AND TREATMENT OF PTSD AT THE END OF LIFE
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Background: The lifetime prevalence of posttraumatic stress disorder (PTSD) is approximately 7% in the general population (1), but it is much higher in selected populations (2). Patients with, or who have survived a serious illness like cancer are at increased risk of PTSD (3). This Fast Fact addresses how PTSD can manifest in seriously ill patients and offer management strategies.

Definition: PTSD is a diagnosable condition that is defined by the DSM-5 as a trauma-related disorder that develops after an individual experiences or witnesses a traumatic event, or learns of a family member who experienced a violent or accidental traumatic event, involving actual or threatened death, serious injury, or sexual violence (4). Symptom manifestation, intensity, duration (>1 month) and the degree to which they disrupt a person’s social/occupational functioning help differentiate PTSD from normative responses to traumatic or stressful events. PTSD symptoms are divided into four groups:
1. Intrusive thoughts (i.e. nightmares, distressing memories)
2. Avoidance (i.e. cognitive/behavioral avoidance of trauma reminders)
3. Negative Mood and Cognitions (e.g. feelings of anger/guilt, negative beliefs about self/others)
4. Hyperarousal (i.e. anger outbursts, hypervigilance, exaggerated startle response).

Assessment: No PTSD assessment tool has been specifically validated for those with serious illness. There are clinician-administered and self-reported tools that can be found at www.ptsd.va.gov, though these can be cumbersome to utilize in practice. Inquiring and listening for themes associated with PTSD (e.g. trauma, avoidance, negative views of self/others/the world, difficulty trusting others, guilt, shame, moral injury) should prompt clinicians to consider PTSD. Involve a mental health professional if feasible since the diagnostic and assessment of PTSD can be challenging.

Interactions Between Serious Illness and PTSD: Receiving a diagnosis of a life-limiting illness and experiencing related symptoms (i.e. pain, air hunger) can elicit feelings of vulnerability and helplessness that may be the index trauma or trigger PTSD symptoms by reminding one of the index trauma (5,6).

- Coping: those living with PTSD may be prone to avoidant coping strategies (remaining physically/mentally occupied, misusing substances to numb emotional experiences, etc.). Serious illness often impedes previously effective PTSD coping strategies (whether healthy or not). For example, someone who typically remained physically active to avoid intrusive memories of the trauma may now be unable to engage in physical activities.
- Medical Decision-Making: the anxiety and emotional challenges that accompany PTSD in serious illness can lead patients to perseverate on treatment options. This can complicate a patient’s ability to make medical decisions, to renegotiate interpersonal relationships, and grapple with existential themes (e.g., one's meaning and purpose in life, legacies they wish to leave behind) (5,6).
- Functional decline: Illness-related functional decline can lead to reliance on others for personal care which can exacerbate PTSD symptoms. This can strain relationships and lead to social isolation, leaving the person at risk of being without caregiver support (5).
- Medication Effects: Medications with hypnotic or sedative properties (e.g. benzodiazepines) may precipitate intrusive thoughts or hyperarousal symptoms via disinhibitory properties (7).
- Pain: A complex, bidirectional relationship can occur, whereby pain influences PTSD symptoms and vice versa (5). As an example, physical pain precipitates intrusive memories, which amplify the pain experience. Some patients welcome pain-relieving measures or seek out the sedative effects of opioids. For others, pain may be tolerated as a form of “redemptive suffering” that assuages guilt about past transgressions. It is crucial to explore PTSD patient's individual relationship with pain.

Stepwise Approach to Psychosocial Palliative Care: Three main non-pharmacologic, psychotherapeutic approaches have been recognized for PTSD: Exposure Therapy, Cognitive Processing Therapy, and Eye Movement Desensitization Reprocessing (EMDR) therapy (6,8,9). While good evidence substantiates the effectiveness of these therapies, they may not always be practical in patients with serious illness (6,9). A stepwise psychosocial approach, allowing for interventions based on
patients’ needs and prognosis, has been proposed for PTSD in the seriously ill which are best provided in conjunction with trained mental health professionals given the complexity and sensitivity of PTSD (9).

1. **Assess the patient’s perceived sense of safety and facilitate a safe environment for the patient.** For example, announce yourself by asking permission before entering a patient’s room; inquire about environmental/physical/social triggers for distress/anxiety such as sounds, smells, inability to view exits; if needed to awaken the patient, call their name but avoid physical touch; reconsider the clinical necessity of diagnostic tests that could trigger PTSD symptoms (e.g. MRI).

2. **Provide psychoeducation to the patient, family, and clinical team regarding PTSD symptoms and how they may be influenced by serious illness.** Teach coping strategies such as relaxation techniques.

3. **Employ trauma-focused psychotherapeutic methods** (see above) with a mental health professional.

**Pharmacotherapy:** Pharmacotherapy has been associated with modest reductions in distressing PTSD symptoms (10); no trials have assessed interventions specifically in seriously ill populations, however. Choosing a medication should be based on life-expectancy, comorbid symptoms/illnesses, and the overarching goal of palliating distressing symptoms.

- **Selective serotonin reuptake inhibitors (SSRIs):** First-line pharmacotherapeutics for PTSD (10). Consider prognosis, as SSRIs take weeks to show effect.
- **Serotonin norepinephrine reuptake inhibitors (SNRIs):** Though supported by less evidence than SSRIs, venlafaxine or duloxetine should be considered if there is comorbid neuropathic pain (11).
- **Mirtazapine:** Though frequently used to treat depression in palliative care settings, there is no high-quality evidence to suggest it helps with PTSD symptoms (12,13).
- **Alpha-adrenergic antagonists:** Prazosin may reduce PTSD-related nightmare severity and frequency in adults, children, and adolescents (14,15). See **Fast Fact #88** for more information on nightmares.
- **Benzodiazepines and antipsychotics:** These medication classes are not recommended for and may even worsen core PTSD symptoms in the general patient population (7,16). Though they are commonly utilized as sedative-like agents for anger outbursts or for when prognosis is felt to be short (e.g. hours-weeks), there is no published high-quality evidence to support this practice.
- **Ketamine, MDMA, cannabinoids:** not currently recommended but active investigations are ongoing.

**References**


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Conflicts of Interest: No disclosures

Version History: First electronically published in May 2020; originally edited by Sean Marks MD

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the Palliative Care Network of Wisconsin (PCNOW); the authors of each individual Fast Fact are solely responsible for that Fast Fact’s content. The full set of Fast Facts are available at Palliative Care Network of Wisconsin with contact information, and how to reference Fast Facts.

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