P1-0093

Aches and Pain During Menopause: Women with Cancer History Have Them More Exacerbated Than Women With No Cancer Diagnosis

Filipa Pimenta, João Maroco, Ivone Patrão, Isabel Leal
ISPA - Instituto Universitário; Psychology & Health Research Unit UIPES, Lisbon, Portugal

BACKGROUND: Endocrine and chemotherapy may exacerbate menopausal symptoms such as hot flushes, musculoskeletal and urogenital symptoms, and cognitive impairment in women with breast cancer (Loibl et al., 2011). A larger study on menopause with Portuguese women was undertaken and a small sample of women with a cancer diagnosis was studied in the present research. Therefore, this research aims at exploring the differences between menopausal symptoms' severity, comparing menopausal women with and without a cancer diagnosis. METHOD: This cross-sectional study encompasses a community sample of 34 Portuguese women (M = 52.5; SD = 5.005) in peri- and postmenopause. Menopausal symptoms were assessed with the Menopausal Symptoms' Severity Inventory, MSSI-38 (Pimenta et al., 2012). The menopausal status was asserted according to the STRAW criteria (The North American Menopause Society, 2012). This study compares 17 women with history of cancer (13 women are breast cancer survivors, 2 women with the diagnosis of ovarian cancer and 2 women with diagnosis of cervical cancer) with 17 women without clinical history of oncologic disease. Both groups are equivalent in terms of menopausal status. RESULTS: There were no significant differences between the two groups in almost all sets of measured symptoms (depressive mood; perceived loss of control; anxiety; cognitive impairment; vasomotor symptoms; numbness; mouth, nail and hair changes; skin and facial hair changes; urinary symptoms; sexual symptoms; and body shape changes). However, there were significant differences in terms of aches and pain (t (32) = −2.112; p = 0.043): women with a cancer diagnosis experienced more severe aches and pain than their counterparts without this diagnosis. CONCLUSIONS: In this sample of menopausal women, participants with a diagnosis of cancer experienced more aches and pain than their counterparts with no oncologic disease. There were no differences between the two groups of women regarding other menopausal symptoms which included self-reported psychological, physical, sexual, and vasomotor symptoms, and cognitive function. RESEARCH IMPLICATIONS: This research concludes, using a small sample of women with cancer diagnosis (breast, ovarian or cervical cancer), that women who have had an oncologic disease experience more aches and pain during the menopause, but don't present a higher severity on other menopausal symptoms when compared with menopausal women with no cancer history. These results need to be confirmed in larger samples and multifactor analysis should be undertaken to assess the contribution of other factors. CLINICAL IMPLICATIONS: Peri- and post-menopausal women with cancer history should be carefully assessed regarding aches and pain since in this sample they manifested more severe symptoms of this kind than menopausal women with no cancer history. ACKNOWLEDGEMENT OF FUNDING: This research was funded by the PhD grant SFRH/BD/32359/2006, of the Portuguese Foundation for Science and Technology (FCT - Fundação para a Ciência e Tecnologia).

P1-0338

EMDR and Cancer. A Pilot Study to Evaluate the Effectiveness of EMDR in a Sample of Cancer Patients

Cristina Civilotti[1,2], Stefania Sacchezin[3,4], Tiziana Agazzi[3,4], Gabriella Modolo[3,4], Elisa Poli[3,4], Chiara Callerame[1,4], Elisa Faretta[3,4]
[1]University of Turin, Turin, Italy, [2]Edo and Elvo Tempia Foundation, Biella, Italy, [3]Centro Studi PIIEC - Psicoterapia Integrata Immaginativa ad Espressione Corporea, Milan, Italy, [4]Associazione per l'EMDR in Italia, Milan, Italy

BACKGROUND: The diagnosis and treatment of cancer are potential traumatic stressors, even if the specific triggers that cause PTSD-like symptomatology are uncertain. The cancer experience embraces a long series of traumatic events, which may begin at the time of diagnosis and continue for several years following treatment. The EMDR (Eye Movement Desensitization and Reprocessing) approach is an empirically validated treatment for traumatic life experiences, including negative life experiences which commonly occur during medical practice (Shapiro, 2014). METHOD: Criteria for participation in the study included documented cancer disease and approval by the subject. Participants were 18 cancer patients in treatment (stages I-III), with mixed diagnosis. Patients were administered at baseline (T0), after 6 sessions (T1) and after 12 sessions of EMDR (T2), with the SCL-90 Symptoms Checklist (Derogatis et al., 1973), the Cope Inventory (Carver et al., 1989), the Davidson Trauma Scale (Davidson et al., 1997) and the Post-Traumatic Grow Index (Tedeschi, Calhoun, 1995). RESULTS: We performed the Friedman test to assess the significance between the data at T0 and the values obtained at T2. A P-value of less than 0.01 was considered significant. After 12 session of EMDR, our sample reported a remission of the PTSD symptomatology (re-experiencing, avoidance and hyper-arousal). Furthermore, we found a

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decrease in mean scores concerning somatization disorders, obsessive-compulsive disorder, feelings of personal inadequacy and hostility, anxiety and depression, phobias, sleep disorders, paranoid ideation and psychoticism. Active coping strategies and positive reinterpretation were improved, while there were no significant changes with regard to religious coping and use of social support. CONCLUSIONS: Interpretation of our data must be considered exploratory due to the small sample size and the lack of a control group, but the quantitative and qualitative data consistently suggest that the participants experienced clinically significant and worthwhile outcomes. The processing and elaboration of past and present traumas appear to be particularly valuable to cancer patients. The EMDR protocol seems to lead to a significant reduction in the various forms of psychological complications that arise as a result of a cancer diagnosis, not only in the post-traumatic symptomatology spectrum, but also in other domains of psychological problems. RESEARCH IMPLICATIONS: Although the use of EMDR protocol in the psycho-oncological context has shown some promises as an effective intervention, especially for post-traumatic stress symptomatology, well-controlled comparative outcome studies are required to establish its efficacy. Moreover, randomized studies on larger samples are needed to generalize our findings regarding the EMDR efficacy with this population. CLINICAL IMPLICATIONS: In an holistic perspective, the AIP (Adaptive Information Processing, Shapiro 1995, 2001, 2002, 2007; Solomon and Shapiro 2008; Shapiro and Laliotis, 2011) model and the use of the EMDR protocol were useful to process the most challenging aspects of both traumatic events in the patients' pasts and their emotional experiences with the disease itself (e.g. diagnosis, surgery, chemotherapy, etc.). ACKNOWLEDGEMENT OF FUNDING: We thank the Centro Studi PIEC (Psicoterapia Integrata Immaginativa ad Espressione Corporea, Milan–Italy), the Edo and Elvo Tempia Foundation (Biella–Italy) and the Italian EMDR Association for their support in this study. A special thanks to the patients participating in this project.

P1-0610

Emotional Vulnerability in Cancer Patients

Maria Die Trill[1,2], Javier Monsalvo[1], Cristina Delgado[1]
[1]*Hospital Universitario Gregorio Marañón, Madrid, Spain,* [2]*Universidad Complutense, Madrid, Spain*

BACKGROUND: Feeling vulnerable is frequently expressed by cancer patients. Fear, uncertainty, lack of hope, helplessness, physical symptoms, mistrust in treatments, poor doctor-patient relationship, lack of social support, advanced disease, emotional distress, faltering capacity to cope with concurrent problems, and pessimism, have been associated to increased feelings of vulnerability (FV) following diagnosis (Weisman, 1976, Grinyer, 2010). PURPOSE: learn about FV in cancer patients along the disease continuum and design efficient psychological treatments to reduce them. METHOD: We developed a brief questionnaire evaluating feelings of vulnerability and variables potentially associated with them. This is an ongoing, descriptive study comparing feelings of vulnerability in patients receiving active cancer treatment (hospitalized vs. ambulatory) and cancer survivors. We have interviewed 20 adult hospitalized cancer patients (10 males) receiving chemotherapy. We are currently interviewing ambulatory patients receiving chemotherapy and cancer survivors as well as additional hospitalized patients receiving cancer treatment.
RESULTS:

- Over 50% of patients reported FV between 6 and 10 (scale 1–10)
- 35% of patients felt more vulnerable when hospitalized (fatigue, loneliness, medical procedures, sadness); 30% felt more vulnerable at home (not being near their doctor/hospital, pain); 25% were equally vulnerable at home than in hospital
- Physical limitations; medical tests; dependency; pain; depression; general malaise; loneliness; inability to control emotions; and chemotherapy increased FV
- 60% of patients reported FV when feeling uncertainty
- Coping strategies identified by patients to deal with FV: anger, distraction, family support, contacting their physician, sleeping, crying and sharing feelings with others.

CONCLUSIONS: Feelings of vulnerability are frequently experienced by cancer patients and seem to be related to medical as well as psychosocial variables. Uncertainty and depression play an important role in the development of these distressing feelings. RESEARCH IMPLICATIONS: Little has been systematically researched on FV in the cncer setting. This study may serve as a basis for further research to be conducted on this topic. It illustrates the need for further investigations given the intensity and frequency with which cancer patients report feeling vulnerable. CLINICAL IMPLICATIONS: We are developing a psychosocial intervention to reduce feelings of vulnerability in cancer patients based on our limited results, based on:

- Increasing patients′ perception of control (provide accurate medical information; anticipating treatment side-effects and ways of controlling them; increasing patient participation in medical decisión-making)

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