The Intersection of Oncology and Sexual Violence: A Case for Trauma-Informed Cancer Care

Melissa A. Peace, MD
Department of Psychiatry and Behavioral Sciences, MUSC

INTRODUCTION

- At least 150,000 of those with new cancer diagnoses annually have histories of traumatic stressors, representing a conservative 10% of the 1.5 million people diagnosed each year. [1]
- A "trigger is anything (e.g., a sight, sound, smell, touch, taste or thought) associated with a past negative event that activates a memory, flashback or strong emotion.[2]
- In this case report, we examine specific triggers within oncologic care, barriers to treatment adherence, and explore the utility of incorporating trauma-informed strategies within this setting.

FIGURE 1

Oncologic care poses triggers to those with underlying trauma histories and/or disorders and may lead to dissociative events that can clinically present as treatment non-adherence.

CASE REPORT

- 35 year old female, G4P4, presents to care for abnormal uterine in the setting of prior abnormal pap smears. Her last pap exam was 3 years prior following the delivery of her child, results were abnormal, and she was told to follow up given the risk of cervical cancer, but did not attend subsequent appointments.
- Subsequent cold knife cone procedure is performed, complicated by posterior cervical perforation with hemorrhage requiring emergency hysterectomy and ultimately yielding a diagnosis of stage IB2 squamous cell carcinoma of the cervix.
- Following surgery she is started on chemotherapy and radiation, including internal brachytherapy. She misses multiple appointments for both chemotherapy and radiation. Due to nonadherence, and side-effects from chemotherapy, radiation alone is decided to be the best fit for therapy by her medical oncologist.
- SW is consulted for assessment due to multiple missed appointments. Patient reports history of sexual abuse with symptoms consistent PTSD, including dissociative events during appointments and treatment, and avoidance of care. Patient is referred to a multi-disciplinary psycho-oncology team.

DISCUSSION

- **Radiotherapy is a "high-risk trigger"** for childhood sexual assault survivors as it involves the complexity of "undressing, being touched in "private areas," and having to lie perfectly still throughout or risk injury.
- In light of the re-traumatizing nature of cancer care itself and the prevalence of sexual trauma, we urge oncology providers to perform holistic social and psychiatric histories comprehensive of sexual trauma, and to continually consider it a relevant part of the patient's presentation.
- Given the association of peritraumatic dissociation and the development of Post Traumatic Stress Disorder (PTSD), and the understanding that PTSD is more common in survivors of cancer than the general population, providers must have a low threshold for further evaluating patients who display an avoidance pattern of coping such as missed appointments.[3,4]

CONCLUSIONS

- The very procedures meant to diagnose and treat cancer can be reminiscent of initial abuse for survivors of interpersonal violence.
- Oncologic non-adherence should raise questions of psychiatric co-morbidity and warrants screening.
- Given the high prevalence of sexual violence, it is critical to attend to the intersection of cancer care and sexual violence in order to provide sensitive and compassionate cancer care.
- Multidisciplinary psycho-oncology teams can assist with psychiatric co-morbidity.

REFERENCES

1. Lawson, K. C., & Lawson, D. H. (2018). Insights into the Psychology of Trauma Should Inform the Practice of Oncology. *The Oncologist*, *23*(7), 750–751.
2. Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. (2008). Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual abuse. Ottawa: Public Health Agency of Canada.
3. Pacella, M., Irish, L., Ostrowski, S., Sledjeski, E., Ciesla, J., Fallon, W., Spoonster, E., & Delahanty, D. (2011). Avoidant coping as a mediator between peritraumatic dissociation and posttraumatic stress disorder symptoms. *Journal of Traumatic Stress*, *24*(3), 317–325.
4. Swartzman, S., Booth, J., Munro, A., & Sani, F. (2017). Posttraumatic stress disorder after cancer diagnosis in adults: A meta-analysis. *Depression and Anxiety*, *34*(4), 327–339.