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The role of child abuse and age in vulnerability to emotional problems after surgery for breast cancer

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ABSTRACT

Emotional problems are common after breast cancer, but patients differ in their vulnerability. Childhood abuse is a risk factor for emotional problems in adult women, and we tested whether it explains some of the variability in emotional problems after breast cancer. Women with primary breast cancer (N = 355) 2–4 d after surgery (mastectomy or wide local excision) self-reported current emotional distress, post-traumatic stress, self-blame, bodily shame and recollections of childhood sexual, physical and emotional abuse. Multiple logistic regression analyses tested the relationship of each emotional problem to abuse, distinguishing three age-groups, divided at 50 and 65 years. Emotional distress, post-traumatic stress, self-blame and shame were present in 49%, 8%, 22% and 13% of women, respectively. Each problem was more common in women who recalled one or other form of abuse. Apart from emotional distress, emotional problems were less common in older women. Older women were also less likely to recall abuse, and recall of abuse contributed statistically to explaining the relationship of youth to emotional problems. Childhood abuse is a risk factor for emotional problems after surgical treatment for breast cancer, and the challenge of identifying and helping those patients in whom emotional problems reflect premorbid vulnerabilities needs careful consideration. Because both emotional problems and abuse are strongly age-linked, future research should avoid generalisations across the age spectrum.

1. Introduction

Despite advances in surgical and medical treatment, breast cancer remains a life-threatening disease, and its diagnosis and treatment have profound emotional consequences. Clinical levels of anxiety or depression are found in a third of patients around the time of surgery and half are affected at some time during the first year.[1] Symptoms of post-traumatic stress disorder (PTSD) are also present in a minority of patients after diagnosis.[2] Clinically, it is important to understand why some women are more vulnerable to emotional problems than others. Although the severity of emotional problems after breast cancer is greater in more advanced disease,[3,4] the variability between individual patients' reactions to objectively similar disease indicates the need to examine patient factors that influence their vulnerability.[1] Previous traumatic stress has been associated with increased vulnerability to emotional distress after cancer,[5,6] and there is some

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evidence that stressful life events predispose patients with breast cancer to develop psychiatric problems.[1,3,7]

Childhood abuse is reported by about a fifth of adult women in community samples[8,9] and physical and emotional abuse are even more common.[10] Women who recall child sexual abuse have increased risk of a range of emotional problems as adults[11–13] and increased vulnerability to depression following threatening life events.[14] It is not known whether this vulnerability is present after cancer. We therefore tested the theory that women who recall childhood abuse are at greater risk of emotional problems after treatment for breast cancer. To find no such relationship would suggest that the vulnerability normally associated with abuse is overwhelmed by the emotional trauma associated with diagnosis and treatment. A positive result would indicate the need for further work to show whether it reflects the persistence of the premorbid relationship or an effect of cancer to increase or weaken this. We examined four emotional problems that affect many patients with breast cancer, and that have been associated also with abuse[11–17]: emotional distress; post-traumatic stress; self-blame; and bodily shame. Self-blame is important, not just because of its intrinsic burden to patients but because patients who blame themselves for breast cancer are at greater risk of anxiety during the first year after diagnosis.[18] Clinically, many women describe feeling ashamed about breast cancer or its treatment, particularly mastectomy,[19] and shame can delay seeking help about cancer-related symptoms.[20]

There have been some reports that, after breast cancer, older women are less vulnerable to emotional distress than are younger women,[21–27] although opposite findings have also been reported,[28,29] as have complex interactions of age with geographical, demographic and clinical characteristics.[30,31] Therefore, to avoid generalising across the age-range of sufferers, we distinguished different age-groups. Many previous studies have distinguished 'older' women as over 50 or over 65. We therefore followed Baider and colleagues[30] in distinguishing three groups, divided at 50 and 65. The younger division reflects the average age of menopause and the age at which routine breast cancer screening begins in the UK; the older division reflects sociodemographic and other health changes and the age at which routine screening ends in the UK.

2. Methods

2.1. Participants and recruitment

Participants were female patients who had received a diagnosis of primary breast cancer followed by mastectomy or wide local excision. We excluded patients: with metastatic or recurrent cancer; receiving neo-adjuvant chemotherapy or primary endocrine treatment; with insufficient English to consent and complete questionnaires; and who were judged by a clinician or the researcher to be too distressed to take part. After ethical approval, 474 suitable women were asked for consent.

Patients were informed about the study by a breast nurse at pre-operative assessment, and were then asked for consent by the female researcher 2–4 d post-operatively before discharging home. The researcher administered questionnaires (see below) to consenting patients privately, and collected clinical information from patient records. Where patients were unable to complete questionnaires in hospital, or were discharged before 2 d, the procedure was completed as soon as possible after discharge.

2.2. Measurements

The 12-item version of the General Health Questionnaire was used to detect emotional distress, as recommended for breast cancer populations.[33] The four-point response scale was scored using the GHQ method (0, 0, 1, 1), a total of 3 and above indicating clinically significant distress.[34] The Post-Traumatic Stress Disorder Scale – Civilian (PCL) has 17 items, scored 1–5, and has been used previously in breast cancer populations.[35] Scores of 50 and above indicated post-traumatic stress.[36] Answers to two questions measuring behavioural and characterological self-blame[37] were summed to indicate self-blame. Scores were dichotomised to distinguish those describing no self-blame from those identifying any degree of self-blame on either or both questions. The Bodily Shame subscale of the Experience of Shame Scale contains 4 items.[38] Scores were dichotomised to distinguish those of 12 or more (corresponding to a mean response to each item of 'moderately' on the four-point Likert scale, scored 1–4: not at all, a little, moderately, very much) from the rest.

The retrospective detection of sexual abuse is complicated by a tendency for under-reporting.[39] Although reports from self-report questionnaires and interviews overlap extensively,[40–42] respondents in one study overwhelmingly preferred a questionnaire to interview[43] and questionnaires can elicit positive responses which face-to-face interviews do not.[44,45] Several self-report procedures have been developed to document recall of childhood abuse, although psychometric properties of many are not yet well characterised.[46] Procedures vary in their complexity for respondents and there is no evidence that more complex procedures are superior.[46] We therefore detected sexual abuse by three self-report questions that have been used in several population surveys,[13,43,45] which asked whether an older person: 'touched or fondled your private parts'; 'made you touch them in a sexual way'; or 'attempted or completed intercourse'. Abuse was indicated by a positive response ('once', 'several times' or 'often' *vs.* 'never') to any question. Recalled physical and emotional abuse were assessed by the questions described by Drossman and colleagues,[47] and subsequently widely used in clinical populations with physical health problems: when a child: 'did an older person hit, kick or beat you'; or 'insult or humiliate you or try to make you feel guilty'? Abuse was indicated by responses 'seldom', 'occasionally' or 'often' *vs.* 'never'. For each question, childhood was defined as less than 16 years old. Establishing the validity of measures of abuse is constrained by the absence of a gold standard and because many victims tell no one about the abuse. Self-report of sexual abuse using the questions employed in the present study among twins was associated highly significantly with the co-twin's reports of the index twin, while the modest level of absolute agreement reflected under-reporting by the co-twin.[43] Reliability information specific to these abuse items