The Oncologist®

Commentary

Insights into the Psychology of Trauma Should Inform the Practice of Oncology

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Disclosures of potential conflicts of interest may be found at the end of this article.

Drs. Giesler, Gaertner, Taden, and Theobald correctly point out that oncology patients can benefit from knowledge gained from the study of trauma [1]. They appropriately wrestle with evolving definitions of trauma, including events and reactions to events. Oncologists are generally familiar with outward manifestations of an ongoing effect of trauma such as post-traumatic stress disorder (PTSD), but we are likely less familiar with the extent to which some people essentially shut down and stop processing when confronted with danger or threat. Just as outward signs of PTSD may become patterns, so may withdrawal [1]. Many patients have experienced trauma prior to getting cancer; those who unconsciously shut down may also shut down when facing a malignancy. We agree that information should be conveyed so as to minimize traumatic effect, but it is important to emphasize the listening component of communication as well, including paying close attention to nonverbal information. We recommend working toward a trauma-informed approach in oncology that allows providers and organizations to begin to address the problems associated with previous trauma, cancer diagnosis-related trauma, and re-traumatization through medical treatment and procedures.

How many patients have experienced significant trauma prior to cancer diagnosis? One representative study reported that 45% of patients in a primary care clinic had suffered some childhood adversity [2]. A recent study of exposure to violence, crime, and abuse in the U.S. noted that 41.2% of children and youth had experienced a physical assault in the past year, 10% had experienced an assault-related injury, and 13.7% had experienced maltreatment by a caregiver. Almost 11% of girls age 14–17 had experienced sexual abuse during that year [3]. In addition, many people undergo significant trauma as adults. Current data do not show that victims of trauma are any more likely to develop cancer than controls (reviewed in [4]). Conservatively, however, because over 1.5 million people are diagnosed with cancer annually, if only 10% of them have significant exposure to past traumatic stressors, at least 150,000 people annually view a new cancer diagnosis through the emotional lens of prior trauma.

Does a history of trauma affect emotional responses to cancer? In one study of 20 breast cancer patients undergoing breast-conserving radiation therapy, 8 (40%) had past childhood trauma. These traumatized patients were significantly more likely to have symptoms of fatigue, depression, or stress than patients without this history [5]. Patients with history of abuse had elevated levels of circulating inflammatory cytokines compared with those without such history, perhaps supporting the notion that levels of inflammatory agents may reflect a molecular mechanism by which the experience of trauma biologically embeds itself in its survivors [1, 6].

Are there significant numbers of providers who have experience with personal trauma themselves? One recent study found that 42.4% of female and 24.3% of male Massachusetts primary care providers reported some experience of personal trauma, which included witnessing violence between their parents [7]. The trauma experience had no detectable negative influence on how these physicians dealt with their patients.

In some instances, not quantified to our knowledge, caretakers may have also experienced trauma prior to a diagnosis of cancer in the loved one. In some instances, patients themselves have been abusive to their caretakers in the past, or vice versa, and this may continue.

Thus, a history of trauma is common in our patients, their caregivers, and ourselves. Both a diagnosis of cancer and its treatment have many aspects of trauma, especially possible loss of life and altered quality of life, both for the patients and by extension their caregivers. There are thus multiple intervention points, and therefore opportunities, for trauma-informed professionals to attempt to mitigate trauma symptoms and other distress.

Oncologists are already stressed and burned out [8] and may feel inadequately trained to do this work by themselves. To whom, then, should we turn? Our colleagues in psychology, psychiatry, palliative care, nursing, and social work have been our main partners, but they are also stressed, and there are not enough of them to do all that needs to be done. Fortunately, there is preliminary evidence (or at least suggestions) that trauma-informed care can reduce this burden by reducing negative impacts on patients. Increasingly, however, patients seek out yoga teachers, life coaches, massage therapists, and other trauma-informed skilled and caring individuals to meet needs that we do not, and perhaps cannot, meet. Unfortunately, they also seek counsel and treatment from individuals providing

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dubious benefit. We need evidence to help us determine which treatments, and which providers, objectively benefit patients in measurable ways so that we can all be effectively integrated into a system of trauma-informed care. We also need to measure the quality of all aspects of the treatment cancer patients receive. To complicate things, it is not totally clear how much of the benefit to the patient is dependent on the therapist and how much on the technique. To a large extent, in these matters Dr. Peabody's words are true: "The secret of the care of the patient is in caring for the patient" [9]. Perhaps, although we cannot measure caring, we may learn to measure its effects.

Optimal treatment of these patients will be an entire encompassing approach and not just a series of interventions. The Substance Abuse and Mental Health Services Administration (SAMHSA) states that trauma-informed programs, organizations, or systems should (a) realize the extensive impact of trauma as well as possible avenues for recovery; (b) recognize the ways in which trauma may affect individuals involved with the system, including patients, caregivers, hospital staff, and health care providers; (c) respond by infusing trauma awareness into the policies, practices, and procedures of the organization; and (d) resist re-traumatization [10]. A trauma-informed approach includes acknowledgment of the potential for secondary victimization or compassion fatigue and features a self-care component for health care providers. Perhaps some of the emerging techniques for promoting resilience in our patients may be helpful to providers as well.

According to SAMHSA, the key principles upon which trauma-informed care is based are "safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues." As an increasing number of health care systems begin integrating the principles of trauma-informed care, further research will be needed to refine these concepts and identify best practices [11, 12].

We concur with Drs. Giesler, Gaertner, Taden, and Theobald that care of cancer patients can be improved by application of knowledge gained in the study of trauma. Concretely, we would recommend that oncologists and others involved in care of these patients begin to incorporate some of this knowledge into their practices. We also acknowledge as above that the need exceeds our capacity and encourage evidence-based use of skills and practitioners outside traditional psychology and medicine. Finally, we will need institutional commitment as well as personal commitment to efficiently integrate all our efforts and to ensure that we use evidence-based, tested approaches to the extent possible as we work to make care of cancer patients more trauma informed.

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Editor's Note:
See the related commentary, "Cancer Diagnosis: A Trauma for Patients and Doctors Alike," by Frank Gieseler et al., on page 752 of this issue.