

Commentary: "My Husband Affects Me More Than My Cancer": Reflections on Simultaneous Intimate Partner Violence and Breast Cancer Experience in a 48-Year-Old Woman

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ABSTRACT

We present our commentary about the case of a 48-year-old woman diagnosed with early breast cancer, already presented as publication. A candidate for mastectomy, she refused immediate reconstruction. She was referred to a psycho-oncologist for further evaluation and support. Psychological sessions helped reveal a history of intimate partner violence and helped clarify the reason for her refusal to undergo immediate reconstruction and other uncommon behavior about oncological treatment and disease paths. Our experience highlights the importance of a multidisciplinary practice in which collaboration between surgeons, oncologists, and mental health professionals leads to a more in-depth understanding of the apparently paradoxical behaviors of patients, and to better care for their needs.

Violence against women is a worldwide public problem^{1,2} nowadays. According to the World Health Organization its prevalence in 79 countries is over 30%^{1,3}. Women are generally exposed to a variety of male violence, particularly husband or lover violence¹. In Europe approximately one woman out of three^{4,5} experiences intimate partner violence (IPV).

Breast cancer (BC) is one of the most important female public health problems in Western Countries. BC is a multidimensional disease that affects women physically, psychologically and socially¹. In Europe one woman out of eight develops BC during her lifetime. The number of women who will simultaneously experience BC and IPV is still unknown^{1,5}, but we could hypothesize that its prevalence is relatively high¹.

Literature describes both the direct and indirect impact of a violence experience on the BC process. Sexual, physical and psychological violence could worsen BC care paths, delay screening and/or diagnosis, decrease quality of life over the disease period and worsen survival¹.

Research has observed that women's psychological and mental problems related to a violence experience have a strong impact on cancer diagnosis and/or treatment. Women develop psychological

and behavioral alterations over the diagnostic and therapeutic process^{1,6,7}; showing higher distress and depression scores^{1,8}. IPV and abuse in childhood (CA) correlate with cancer-related psychological problems such as feeling more tired and having lower specific physical and emotional welfare^{1,9}. Finally, violence is a risk factor for the development of emotional problems after BC surgery^{1,10}.

However the number of studies on this subject is limited^{1,5}. The relationship among IPV, CA, other violence related symptoms and BC needs to be investigated in detail^{1,8}. The psychological reasons at the origin of abused women's behavioral alterations in coping the BC experience are still not clear. The role of the personal illness in the marital relationship and the strategies that women adopt to cope with their body changes are also still not clear.

Our manuscript describes an example of a personal strategy adopted by a dependent and abused woman in dealing with a life-threatening disease, and highlights how the experience of body loss in BC could be based on personal perceptions of her own breast and, more broadly, of self-identity and self-awareness. The article furthermore shows the influence of a woman's personal history of fragility on IPV and on her cancer care continuum¹⁰.

We reported the case of a 48-year-old, highly educated, middle class woman, who showed contradictory attitudes and behavior during her diagnostic and therapeutic BC sessions. At the first surgical visit she adamantly refused the proposal of breast reconstruction, during her chemotherapy treatment she asked her oncologist to refrain from giving any good news to her husband. In the presence of health staff she never showed anxiety or signs of depressed mood about her cancer or chemotherapy side effects. When she received the bad news of a diagnosis of lymph node metastasis, she seemed to neglect her disease and never complained of fear or angst.

At the same time the patient was compliant with her physicians' indications, during all of the stages of medical intervention. She never complained about chemotherapy side effects: body changes did not seem to be really a problem for her.

From her instances of contradictory behavior between her compliance to treatment and her apparent emotional denial of good and bad news, the medical staff suspected unspoken needs and asked for a psycho-oncological intervention. After more than one meeting with the psycho-oncologist, the patient revealed to be victim of IPV: that she had been living a marital relationship characterized by violence for more than 20 years. The IPV consisted of psychological aggression and physical abuse against her and her six children. They had been referred to the Accident and Emergency Department after more than one serious knife-throwing assault. A psychiatric evaluation

was set up, and antidepressants were prescribed. During the following four years of her BC diagnosis, through the psycho-oncological support, she was able to recognize her IPV problems and to identify her major life events that brought her to choose a violent partner. An effect of her psychotherapeutic process enabled her to remember an early CA. She started to recognize her personal reality and gradually became more self-aware of her feelings and needs. As a result of this process, she began to wonder about her cancer disease evolution and to feel angst: she stopped using her disease as a protection.

This case showed us how specific mental mechanisms of abused women could condition their cancer care. Differently from other studies, this woman did not refuse the cancer diagnosis or decided to abandon her treatment, despite their invasiveness and severe consequences on family daily routines¹¹. Similarly, her partner, who often accompanied her to the hospital, did not show denial behavior: he seemed to share in her cancer care and to support her physical needs¹¹. How did she use her own disease and sick body in a couple relationship characterized by IPV? The patient had been asking physicians not to eradicate the signs of cancer from her body, but to make those signs on her body as evident as possible: she wanted to project a poor body image and exhibit her body cancer signs to appear ill. This seemed to be her strategy to manage her submissive relationship with her husband. She asked her physicians to be complicit in disclosing her mutilated body and physical damage, as a consequence of her identification into the pattern of the sick role ("I am my sick body") and to keep her violent husband "in check".

Moreover in this case we observed the clinical depression^{1,5} arising from feelings of self-deprecation previous to the IPV experience. In literature we think that this subject is not always fully discussed. Our patient showed us that the psychological reasons of her affective dependence should be placed in her early CA history^{12,13}, that substantially impacted on her self-identity⁵ and self-awareness of her feelings and needs. In our clinical experience a diagnosis of BC could often disclose patient's mental health vulnerability¹⁰. In our experience, this condition of mental fragility could obstacle dependent women to cope with the cancer disease experience ("My husband affects me more than my cancer")^{1,5,10,14} and could reduce the patient's chances of seeking for support, particularly from medical staff^{1,5,15}.

The case evolution confirmed the necessity of a multi-disciplinary intervention. Our group started a long term care plan for this patient which enabled her eventually to request help. A constant discussion among the surgeon, the oncologist, the psycho-oncologist, the breast nurse and the psychiatrist was necessary in order to uncover the violence on the patient, evidently considered a "taboo" for her^{1,12}.

Our findings also support the need to reinforce programs that bring attention to the multi-disciplinary care plan, understanding patients' needs and management of their distress factors^{5,16}.

In this commentary we would also highlight the importance of a real multi-disciplinary practice. As confirmed, BC requires a much broader perspective than that of a solely body/physical approach^{5,16}. Moreover integrated and individualized team interventions could really understand the emotional functioning of each woman in dealing with her BC experience during every step of the diagnostic and treatment process.

In conclusion we would suggest the importance of preliminary evaluations, already during diagnostic set, especially in those situations where patient decisions seem to contrast with good clinical practice and also with good common sense⁵. Collaboration between surgeons, oncologists, breast nurses and mental health professionals leads to a more in-depth understanding of the apparently paradoxical behavior of patients, and better care of their needs⁵ during all the treatment process.

Finally, in this age of personalized medicine, the inclusion of psycho-oncological treatment as a complementary medical care treatment, that is customized for an individual patient, should become more commonly adopted⁵.

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