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Cancer Victim Identity for Individuals with Histories of Cancer and Childhood Sexual Abuse

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Abstract

Identifying as a ‘cancer victim’ has been linked to adverse psychosocial sequelae in individuals who have been diagnosed with cancer. Being a childhood sexual abuse (CSA) survivor may predispose individuals towards a “victim” identity in general. The aim of this study was to determine the prevalence of identifying as a ‘cancer victim’ among CSA survivors who were diagnosed with cancer as adults, and to explore psychological factors associated with identification as a cancer victim. 105 adults reporting both a history of CSA and of having been diagnosed with cancer as an adult were recruited through Amazon Mechanical Turk. Variables assessed included CSA severity, abuse-related powerlessness, general mastery, and cancer victim identity. Fifty-one percent of the sample endorsed a cancer victim identity. Path analysis revealed that abuse-related powerlessness was related to decreased feelings of general mastery, which was in turn associated with cancer victim identification ($\chi^2 = .12$, $DF = 1$, $p < .73$; RMSEA = .00; SRMR = .01; Bentler CFI = 1.0). From a clinical perspective, the results suggest that increasing general mastery in CSA survivors in the cancer setting may be an important mechanism for attenuating the risk for developing a cancer victim identity and, presumably, for downstream adverse psychosocial sequelae.

Keywords

Oncology; Identity; Sexual abuse survivors; Mastery

Introduction

Over 1.6 million individuals in the United States are expected to be diagnosed with invasive cancer this year (American Cancer Society 2016), and a diagnosis of cancer can often lead to multiple changes in a person's life. Some of these changes are observable and apparent—hair loss, scars, missed days at work, and the need to take daily medications. Yet other changes, equally important, are not readily observable. For example, individuals often

struggle to define their personal identity in relation to their cancer experience; that is, to develop their “cancer identity.” Four particular cancer identities have been discussed in the literature: seeing oneself as a victim of, a survivor of, a patient with, or a person with cancer (Park et al. 2009). Among these four, a cancer victim identity is the least frequently endorsed, yet it is the most concerning (Bellizzi and Blank 2007; Chambers et al. 2012; Cho and Park 2014; Morris et al. 2014; Park et al. 2009). A cancer victim identity has been associated with a number of negative psychosocial consequences, including lower levels of mental health-related quality of life, positive affect, and life satisfaction; and higher levels of negative affect, hostility and intrusive thoughts (Deimling et al. 2007; Park et al. 2009). Although cancer identity research has highlighted the adverse psychological correlates of holding a cancer victim identity, little research has been conducted to elucidate what risk factors might be associated with the development of such an identity.

Developmental psychology research has suggested that: (1) the core of identity development occurs during childhood (Briere 1992; Josselson 1987; Lieblich et al. 2004); (2) victimization during childhood, such as childhood sexual abuse, can profoundly and adversely affect identity development (Dukett 2015; Martsof and Draucker 2008); and, (3) individuals with a history of childhood sexual abuse can have identities characterized by victimization, where “the world and the self are viewed through the lens of the victimized child” (Philips and Daniluk 2004, p. 177). In light of this past work, it seemed possible that a history of childhood sexual abuse (CSA) could predispose individuals, when subsequently diagnosed with cancer as adults, to adopt a cancer victim identity. However, to our knowledge, no one has ever examined cancer victim identity in a sample of CSA survivors. Therefore, the first goal of our study was to explore whether there is a direct relationship between CSA and cancer victim identity. Specifically, we hypothesized that CSA severity would be associated with cancer victim identity.

The next question we sought to address is how might CSA severity exert its effects on victim identity? Or, put another way, what are the underlying psychological mechanisms? Our approach to answering this question was informed by Dallam’s Healthcare Retraumatization Model (Dallam 2010). This model suggests that CSA survivors can develop a sense of powerlessness and vulnerability associated with their abuse, and that this sense of powerlessness can generalize to other new encounters, including healthcare encounters (Dallam 2010). In the case of CSA survivors diagnosed with cancer, we hypothesized that abuse-related powerlessness could be associated with a more general sense of decreased mastery (i.e., decreased sense of “the extent to which one regards one’s life-chances as being under one’s own control in contrast to being fatalistically ruled”) (Pearlin and Schooler 1978, p. 5). We further hypothesized that this general sense of low mastery could be associated with feeling victimized by a cancer diagnosis. Such a hypothesis is consistent with Park et al. (2009) description of a cancer victim identity as being associated with a sense of vulnerability, lack of agency, and powerlessness. Please see Fig. 1 for a diagram of this hypothesized model. The second goal of the study was to test this hypothesized model, and to explore direct and indirect effects of CSA severity on cancer victim identity.

Overall, results of the present study will contribute to the literature by examining, for the first time, associations among CSA severity, abuse-related powerlessness, general mastery, and cancer victim identification.

Methods

Study Design and Procedures

The study was conducted anonymously on Amazon Mechanical Turk (MTurk), a large crowd sourcing website. MTurk has been recommended as an approach for studying trauma populations because it allows access to large sample sizes, users report similar levels of trauma exposure and psychiatric symptomatology as the general population, and MTurk users indicated that they feel more comfortable disclosing sensitive information in an online format (Shapiro et al. 2013). Additionally, research has indicated that MTurk is appropriate for research with cancer survivors (Arch and Carr 2016). The study was approved as exempt by the Program for the Protection of Human Subjects at our institution. MTurk members were informed about the availability of our survey initially by viewing the survey title, “Survey of childhood sexual abuse history & reactions to cancer care (men and women over 21).” If they were interested, they could click on this title, and view a short description of the study and the study eligibility criteria. The description of the study read, “Participate in a 25–35 min survey for cancer care research. To be eligible, you must: (1) have been diagnosed with cancer after age 21 and (2) have experienced sexual abuse before age 13.” Each participant received \$3.00 for their participation, paid directly through MTurk.

Participants

One hundred and five participants (mean age = 48.9, SD = 7.5) took part in the study. Eligibility criteria included: being over age 21, reporting CSA, as defined by the Centers for Disease Control and Prevention (CDC; Basile et al. 2014), before age 13, reporting a diagnosis of cancer after the age of 21, being an MTurk member, being able to read English, and living in the United States. See Table 1 for the sample characteristics.

Measures

The *Demographic and Medical History Questionnaire* is a face-valid set of items that was used to assess age, gender, race, ethnicity, marital status, education, region, community type, age at diagnosis, cancer type, and treatments received.

The *Sexual Abuse Severity Score (SASS; Zink et al. 2009)* is a five-item index that was used to measure CSA severity. The index is scored such that higher scores indicate greater severity of sexual abuse.

Abuse-related powerlessness was measured by the *Powerlessness Subscale of the Trauma-Related Beliefs Questionnaire (TRBQ; Hazzard 1998)*, is 10-item scale that assesses feelings of personal vulnerability and lack of empowerment associated with CSA. The scale has shown adequate reliability ($\alpha = .78$) and validity in prior research. In this study, Cronbach's alpha for the scale was .87.

General mastery was measured by the 7-item *Pearlin Mastery Scale* (Pearlin and Schooler 1978). The scale is scored such that higher scores indicate a greater sense of mastery. The scale has been shown to have adequate reliability ($\alpha > .70$; Turner and Noh 1988) and validity (e.g., Pearlin et al. 1981). This scale was used here to assess general mastery. In this study, Cronbach's alpha for the scale was .86.

Cancer victim identity was measured using an item developed by Park et al. (2009). Participants were asked how much they consider themselves to be a victim of cancer. The item is rated on a five-point scale (1 = not at all, 5 = very much). The scale is scored such that higher scores indicate a participant's stronger endorsement of the victim label. Any response between 3 and 5 is considered to be an endorsement of a cancer victim identity (Park et al. 2009).

Data Analysis

Chi square, Kendall's tau tests, and Pearson correlations were performed to explore whether the primary study variables were associated with demographic or medical characteristics. Next, Pearson correlations were computed to describe the bivariate relations among primary study variables.

Finally, path analysis was performed using SAS Proc Calis procedure to assess the fit of the hypothesized model (Fig. 1). Cancer victim identity was entered as a continuous variable. Multiple model data fit indices were examined, including the Chi square statistic, the root mean square error of approximation (RMSEA), the standardized root mean square residual, and the comparative fit index (CFI). Model fit was assessed using the following criteria: (a) Chi square statistic and a nonsignificant p value ($<.05$), (b) RMSEA $< .05$ = a close fit, $>.05-.08$ = a fair fit, $>.08-.10$ = a mediocre fit, and $>.10$ = a poor fit, (c) SRMR $<.08$, and (d) CFI best if above .95 (Bentler 1990; Kline 2011). Additionally, Lagrange multiplier indices and the Wald test were examined to inform model modification. There were no model constraints and only standardized coefficients are reported. The magnitude of effect sizes for the path parameter estimates were determined using Cohen's criteria (.10, .30, and .50 for small, medium, and large effects, Cohen 1992). It has been suggested that path analyses are tenable in studies including ≈ 100 participants as long as the model tested is simple (that is, studies requiring the estimation of a low number of parameters, as in the model tested in the present study) (Kline 2011).

Results

Descriptive Statistics

Mean cancer victim identity score was 2.69 (SD = 1.52). Participants' mean score on the SASS was 11.51 (SD = 3.65). Participants' mean general mastery score was 19.20 (SD = 4.21), and participants' mean score on the TRBQ was 1.46 (SD = .68). Table 2 shows bivariate correlations among all study variables. None of the demographic or medical characteristics was associated with any of the primary study variables, all $ps > .05$.

Path Analysis

The initial hypothesized model (Fig. 1) had a good fit ($\chi^2 = 1.56$, $DF = 2$, $p < .46$; RMSEA = .00, SRMR = .03; Bentler CFI = 1.0). Results revealed significant paths between abuse-related powerlessness and general mastery (Standardized parameter estimate (SPE) = $-.75$, $t = -17.48$, $p < .01$), and between general mastery and cancer victim identity (SPE = $-.30$, $t = -3.36$, $p < .01$). The paths between CSA severity and abuse-related powerlessness (SPE = .16, $t = 1.71$, $p > .05$), and between CSA severity and cancer victim identity (SPE = .08, $t = .82$, $p > .05$) were not significant. These findings, consistent with the results of correlational analyses, disprove the initial study hypothesis that CSA severity would be associated with cancer victim identity.

Based on the Wald test statistics, we dropped these two paths in order to increase the parsimony of the model and to improve model fit. Dropping these two paths was also consistent with the analyses of the bivariate correlations (Table 2). The final model (excluding these two paths, see Fig. 2) increased model fit ($\chi^2 = .12$, $DF = 1$, $p < .73$; RMSEA = .00; SRMR = .01; Bentler CFI = 1.0). The path coefficient for the association between abuse-related powerlessness and general mastery was SPE = $-.75$, $p < .01$, a large effect based on Cohen's criteria. The path coefficient for the association between general mastery and cancer victim identity was SPE = $-.31$, $p < .01$, a medium effect based on Cohen's criteria. Both of these effects were almost identical to those in the initial model (see Fig. 2). These results are consistent with study hypotheses suggesting that increased feelings of abuse-related powerlessness are associated with decreased feelings of general mastery, and feeling that one has less general mastery is associated with increased likelihood of perceiving oneself as a victim of cancer.

Once we had a good fitting model, we proceeded to explore direct, indirect and total effects. Table 3 provides the direct, indirect, and total effects of the final path analytic model. As can be seen in this table, the relationship between abuse-related powerlessness and cancer victim identity is indirect only. The effect of general mastery on cancer victim identity is direct. In combination, these results suggest that the abuse-related powerlessness affects cancer victim identity through general mastery.

Discussion

The literature has previously demonstrated that seeing oneself as a victim of cancer is associated with negative psychosocial outcomes (Deimling et al. 2007; Park et al. 2009). Park et al. (2009), using the same victim identity cutoff score as used in the present study, found low rates of cancer victim identity endorsement (18%). The prevalence of endorsing a cancer victim identity in the present CSA sample was 51%. We speculate that the CSA survivors who participated in this study, having already experienced at least one unwanted bodily assault, may be particularly vulnerable to feeling victimized by their cancer relative to individuals without a CSA history.

Interestingly, our results did not reveal an association between CSA severity and cancer victim identity or abuse-related powerlessness. To our knowledge, this study is the first to examine these relationships. It is possible that we failed to find such relationships because it

is not the severity of the CSA that matters, but rather how the past CSA is evaluated and interpreted. Although prior research has indicated a link between the CSA severity and negative health-related quality of life (Dickinson et al. 1999), there is evidence that several factors, including shame, self-blame, family reactions to the disclosure of the CSA, family environment, and coping strategies, may mediate the relationship between CSA severity and psychological consequences (Fassler et al. 2004; Merrill et al. 2001; Whiffen and MacIntosh 2005). Additionally, there is preliminary evidence that negative trauma appraisals predict symptoms of PTSD and depression above and beyond the severity of trauma experienced (Cromer and Smyth 2010; DePrince et al. 2011). The influence of CSA severity relative to other abuse-related variables should be explored further in future cancer victim identity studies.

Next, we sought to understand the relationships between abuse-related powerlessness, general mastery, and cancer victim identity. Path analysis found that a greater sense of abuse-related powerlessness was associated with a decreased sense of general mastery, which in turn was associated with an increased cancer victim identity. These results are consistent with Dallam's Healthcare Retraumatization Model (Dallam 2010), in that abuse-related powerlessness was associated with low general mastery, which appears to set the stage for reacting to cancer with a victim's mindset.

From the clinical perspective, these results suggest that fostering a sense of increased general mastery may be a critical component in reducing feelings of cancer victim identification. We would then speculate that reducing cancer victim identification would promote positive psychosocial adaptation to a cancer diagnosis. Existing sensitive practice guidelines detail how healthcare workers can foster a sense of mastery in patients with a history of CSA (e.g., Havig 2008; McGregor et al. 2010; Schachter et al. 2009). Although the effects of implementing these and other trauma-informed guidelines on the formation of a cancer victim identity have not been studied, they would seem to be a promising area for future investigation.

The present study has several limitations. First, there was no comparison group of individuals with cancer who did not have a history of CSA. Therefore, comparisons of victim identity prevalence between CSA and non-CSA participants were not possible. Future studies should include non-CSA comparison groups to further explore this issue. Second, it is possible that the sample obtained through MTurk may be unique in some ways when compared to the more general cancer population. For example, our sample had a higher proportion of White participants than seen in the broader U.S. cancer population, and the present sample was younger than many other adult cancer samples. Therefore, the results should be replicated in non-MTurk samples. Additionally, it is unclear whether these findings would generalize to non-cancer populations or different types of past trauma. Future studies should expand upon these results by investigating the model tested here in other trauma populations (e.g., physical abuse survivors), as well as in other disease populations (e.g., diabetes, heart disease).

Conclusions

This study is the first to examine cancer victim identity in a sample of CSA survivors. Results revealed that among individuals with cancer and a CSA history, 51% reported a cancer victim identity. Furthermore, a sense of abuse-related powerlessness and reduced sense of general mastery were associated with a cancer victim identity in the path model. More work is needed to develop a better understanding of these mechanisms and to develop and test interventions to address the psychosocial needs of individuals with a history of both CSA and cancer.

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Fig. 1.
Hypothesized path model

Fig. 2.
Final path model

Table 1

Sample characteristics (n = 105)

Characteristic	M (SD)
Age	48.9 (SD = 7.5)
Age at diagnosis	40.5 (SD = 8.9)
	% (n)
Female	66.7 (70)
Race	
White	87.6 (92)
Ethnicity	
Non-hispanic	92.4 (97)
Marital status	
Married/cohabitating	47.1 (49)
Education	
At least some college	81.9 (86)
Region	
Northeast	18.1 (19)
South	46.7 (49)
Midwest	21.0 (22)
West	14.3 (15)
Community	
Suburban	42.9 (45)
Urban	34.3 (36)
Rural	22.9 (24)
Cancer type ^a	
Breast	24.0 (25)
Non-melanoma skin cancer	17.3 (18)
Other (including more than one)	64.0 (61)
Treatments received ^a	
Surgery	78.1 (82)
Chemotherapy	40.0 (42)
Radiation therapy	32.4 (34)

^a Percentages for cancer type and for treatments received do not add up to 100 because participants were able to select more than one response option

Table 2

Correlations between victim identity, CSA severity, abuse-related powerlessness, and general mastery (n = 105)

Variable	1	2	3	4
1. Victim identity	–			
2. CSA severity	.14	–		
3. Abuse-related powerlessness	.26**	.16	–	
4. General mastery	–.31**	–.20*	–.75***	–

*
p .05;

**
p .01;

p .001

Standardized path analytic estimates of direct, indirect, and total effects on cancer victim identity (n = 105)

Table 3

Predictor variables	Total effects				Direct effects				Indirect effects			
	Effect	Std. error	t	P	Effect	Std. error	t	P	Effect	Std. error	t	P
Abuse-related powerlessness	.24	.07	3.40	<.001	0	–	–	–	.24	.07	3.40	<.001
General mastery	–.31	.09	–3.55	<.001	–.31	.09	–3.55	<.001	0	–	–	–