Linking Cancer and Intimate Partner Violence: The Importance of Screening Women in the Oncology Setting

Sandra K. Cesario, PhD, RNC, FAAN, Judith McFarlane, RN, DrPH, FAAN, Angeles Nava, PhD, RN, Heidi Gilroy, MSN, APHN-BC, and John Maddoux, MA

Millions of women in the United States experience physical abuse because of intimate partner violence (IPV) that results in injuries, social and family dysfunction, mental health disorders, chronic pain and illness, and death. Cancer causes a quarter of the deaths of women in the United States. When IPV and a cancer diagnosis intersect, a special population of women with unique needs is created. The purpose of the current study was to determine the rates of IPV and the types of cancer reported by women seeking services for IPV. Safety, community agency use, severity of violence, danger, psychological distress, post-traumatic stress disorder, self-efficacy, social support, pain, and marginality also were assessed. Three hundred abused women were interviewed in person to determine their health, safety, and functioning. Of the 300 women, eight reported receiving a cancer diagnosis, and most of those women had cervical cancer. The prevalence of cervical cancer reported by abused women was 10 times higher than the general population. Higher danger scores and risk for revictimization were reported. Increased awareness of the potential connection between IPV and cancer is needed, and evidence-based strategies that promote IPV screening in the oncology setting should be developed.

Key words: epidemiology; gynecologic malignancies; psychosocial aspects; intimate partner violence

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Cancer incidence and mortality in the United States has decreased slightly since 1990, but it remains a primary health concern. About 25% of all deaths in the United States are attributed to malignancies (Siegel, Naishadham, & Jemal, 2012). Women who have experienced intimate partner violence (IPV) are diagnosed with cancer, particularly cervical cancer, at higher rates than women who have not been abused (Coker, Hopenhayn, DeSimone, Bush, & Crofford, 2009; Dutton, Goodman, Lennig, Murphy, & Kaltman, 2006). A higher incidence of cervical cancer is reported among women who have experienced sexual abuse as adults and children, when compared to women who have experienced other forms of abuse or have not experienced abuse at all (Quinlivan, Petersen, Davy, & Evans, 2004). Chronic stress, depression, lower self-efficacy, smoking, multiple intimate partners, sexual abuse, and childhood physical abuse may be contributing factors that lead to the higher incidence of cancer among adult women who report abuse (Champion, Piper, Holden, Korte, & Shain, 2004; Chida, Hamer, Wardle, & Steptoe, 2008; Dalton, Boesen, Ross, Schapiro, & Johansen, 2002; Fuller-Thomson & Brennenstuhl, 2009; Hamer, Chida, & Molloy, 2009). Although accurate statistics are difficult to compile, an estimated 1.3 million women in the United States are affected by physical assault by an intimate partner each year (National Coalition Against Domestic Violence, 2013). That large group of women who have experienced abuse is less likely to receive preventive women’s healthcare services, including Pap testing and mammography (Gandhi et al., 2010; Farley, Golding, & Minkoff, 2002; Lemon, Verhoek-Offedahl, & Donnelly, 2002; Quinlivan et al., 2004; Wilson, Silberberg, Brown, & Yaggy, 2007). In some instances, women have reported feeling that the abuse could have caused the cancer (Sawin, Laughon, Parker, & Steeves, 2009). Because of emotional and financial strain precipitated by a cancer diagnosis, one study suggested...
that women with cancer actually may become victims of IPV (Schmidt, Woods, & Stewart, 2006). Because of that study’s findings, nurses and other healthcare providers should be aware of the links between IPV and cancer and incorporate IPV screening into routine oncology care.

The purpose of the current article is to report the cancer-related findings from the first year of data collection of an overarching, seven-year prospective study of women who have experienced IPV and who have children. The prevalence of cancer and other health characteristics of 300 English- and Spanish-speaking abused women seeking safe shelter and justice system services were examined. Studying cancer in the context of IPV addresses implications for oncology nurses, as well as for nurses advocating for abused women.

Literature Review

Linking Cancer and Intimate Partner Violence

Evidence in the literature linked women’s cancers with abuse victimization. During an audit of an oncology clinic, Macpherson (2009) noted that 33% of women being treated for a variety of cancer diagnoses reported a history of childhood sexual abuse, with another 9% of women in the same clinic reporting that they had experienced severe physical or emotional abuse. In a similar review of a different oncology clinic, the rising incidence of IPV in adult women resulted in policy changes that called for additional education of the nursing staff and more comprehensive abuse screening for women undergoing cancer treatment (Schmidt et al., 2006).

Links between IPV and cancer incidence fall into the category of physiologic characteristics, with psychosocial, emotional, economic, and historic factors. In addition, women experiencing abuse often will experience multiple types of stress that increase their lifetime risk for developing a cancer diagnosis (Woods, 2005). Variations in cancer rates exist based on the type of violence a woman has experienced, the duration and intensity of the abuse, and the age at which she was victimized. Emotional, physical, and sexual violence inflict wounds that often leave a woman scarred for the remainder of her life.

Physiologic Characteristics

Cervical cancer is the most common malignancy linked to IPV. Even after adjusting for other high-risk behaviors, such as smoking, all types of abuse (e.g., adult partner violence, forced sex, childhood sexual abuse) are strongly correlated with an increased prevalence of invasive cervical cancer (Coker et al., 2009). Several theories have been proposed to account for the phenomenon.

Abused women are less likely to seek preventive healthcare services, elect to have routine cancer screening, or have a primary care provider (Lemon et al., 2002). After other common barriers to accessing health care (e.g., poverty, depression, lack of education, lack of transportation) are considered, IPV still was independently and strongly correlated with a lack of recent preventive gynecologic care and inadequate Pap testing (Black et al., 2011; Loxton, Powers, Schofield, Hussain, & Hosking, 2009). Women older than age 40 who are abused are the most common age group to be late in routine Pap smear testing (Gandhi et al., 2010). Victims of IPV also may have developed avoidance behaviors related to gynecologic care because of the association with sexual violence (Ackerson, 2012). However, it should be noted that access to a primary care provider with whom an abused woman has developed a trusting relationship significantly improves adherence with suggested women’s health screenings (Loxton et al., 2009).

Another reason that cervical cancer may be more prevalent among women who have experienced IPV is the higher incidence of sexually transmitted infections (STI), human papilloma virus (HPV), HIV, and pelvic inflammatory disease (PID) (Allsworth, Anand, Redding, & Peipert, 2009; Bogart et al., 2005; Champion et al., 2004; El-Bassel et al., 2007; Gien et al., 2007). The dysplasias caused by STIs, particularly HPV (types 16, 18, 31, 33, and 45), have been causally related to the majority of cervical cancers (Schiffman, Castle, Jeronimo, Rodriguez, & Wacholder, 2007). Nationwide surveillance monitors reveal that abused women, when compared to the general population, are three times more likely to acknowledge some form of sexual risk behavior (e.g., not using a condom, forced sex) that puts them at greater risk for developing cervical cancer (Black & Breiding, 2008). Partners of those women are more likely to engage in sex with people outside of the relationship, have multiple partners, and be more averse to condom use (Wingood, DiClemente, & Raj, 2000). African American women are at risk for violence, have the highest rates of STIs—including HPV—and, therefore, are at the highest risk of developing cervical cancer (Allsworth et al., 2009).

IPV may be a barrier for other cancer screening procedures, such as colorectal screening and mammography (Watson-Johnson, Townsend, Basile, & Richardson, 2012). The majority of adult abuse survivors shared that they have never had a mammogram or were not up to date on their screening (Gandhi et al., 2010). Wise, Palmer, Boggs, Adams-Campbell, and Rosenberg (2011) reported that a greater risk of breast cancer exists among African American women who suffered adult physical abuse, when compared to abused women of other races or ethnicities.

Psychological and Emotional Factors

Compared to women in the general population, women who disclose a history of IPV are at a higher risk for chronic stress, anxiety, depression, suicide, psychosomatic disorders, low self-esteem, low self-efficacy, poor social support, chronic pain, post-traumatic stress disorder (PTSD), risk-taking behaviors, and illicit drug use (Campbell, 2002; Gandhi et al., 2010; Loke, Wan, & Hayter, 2012; Romans & Cohen, 2008; Wuest et al., 2008). Abused women residing in shelters have the highest rates of mental and functional impairment that adversely affect employment, education, and the ability to function openly and safely in a social setting (Helfrich, Fujiura, & Rutkowski-Kmita, 2008). Providing safety for themselves and their children is a constant source of stress for women in abusive relationships (Cronholm & Bowman, 2009; Ramaswamy, Kelly, Koblitz, Kimminau, & Engelman, 2011). Police intervention often is requested but does not necessarily solve the long-term problem because abused women may continue to live in fear of retaliation and revictimization (Dichter & Gelles, 2012). Prolonged stress, fear, and depression experienced by abused women can trigger complex neuroendocrine and immune system responses.
that decrease cytotoxic T-cell and natural killer-cell activities, making those women more susceptible to cancer and other health concerns (Reiche, Nunes, & Morimoto, 2004; Woods, 2005). Distance from the abusive partner and a strong network of support from family, friends, and healthcare providers is essential to the functioning, recovery, and well-being of women who disclosed that they have experienced an abusive relationship. Social support has been found to decrease depression and improve quality of life for abused women (Beeble, Bybee, Sullivan, & Adams, 2009; Dichter & Gelles, 2012).

Socioeconomic and Environmental Characteristics

Victims of abuse are a marginalized population. They often are viewed as less important than members of mainstream society, and their needs may be trivialized or devalued (Koci, 2004). Feeling afraid, ashamed, trapped, and without resources, victimized women live in a world controlled by the abusive partner (Loke et al., 2012). Women experiencing abuse, incarcerated women, substance abusers, HIV-positive people, patients with cancer, women perceived as being promiscuous, and lesbians all may be considered marginalized groups. Some women may be members of more than one marginalized group, increasing their isolation and decreasing resources. When access to basic care, nutrition, and a healthy lifestyle are denied, cancer risk increases (Kushi et al., 2012). Nurses should be aware that physical, emotional, and sexual abuse can occur between same-sex partners. Lesbians have a higher incidence of most cancers because of a distrust of the healthcare system, poor preventive healthcare, high rates of smoking and obesity, and other factors (Heintz & Melende, 2006).

In a study to determine the incidence of IPV among women with cancer, Modesitt et al. (2006) found that 76% of women being treated for breast, cervical, endometrial, and ovarian cancer had experienced partner abuse as an adult, compared to an estimated 36% of women in the general population (Black et al., 2011). In addition, abused women were more likely to be diagnosed with cancer at a younger age, divorced, smokers, uninsured, and have more advanced cancer at the time of diagnosis when compared to women who were not abused. The current study did not find differences between abused women and those who had not been abused with regard to cancer type, level of education, drug and alcohol use, or race. However, when compared with Caucasian women, Hispanic and African American women diagnosed with cancer tend to have a lower family income, which often is associated with delayed diagnosis and poorer cancer outcomes (Eggleton et al., 2006). Forty percent of women with a history of incarceration have been found to have abnormal Pap tests compared to the general population with a 6% abnormal rate (Ramaswamy et al., 2011).

The evidence suggests that women who experience violence are more than twice as likely to be smokers, have begun smoking at an early age, drink heavily, or initiate smoking and/or drinking during periods of abuse, when compared to women who were never exposed to violence (Lemon et al., 2002). Smoking is associated with lung, larynx, oral cavity, breast, bladder, pancreas, uterus, cervix, kidney, stomach, esophagus, liver, and colorectal cancers (Yoshihama, Horrocks, & Bybee, 2010). Alcohol increases a woman’s chance of developing cancer of the mouth, pharynx, larynx, esophagus, liver, pancreas, colon, rectum, and breast (Allen et al., 2009; Lew et al., 2009). The irritation caused by those substances leads to tissue damage, alters hormone levels, causes fluctuations in weight, and lowers folate levels (Yoshihama et al., 2010). When women smoke or drink alcoholic beverages, cancer risk increases proportionately with the amount consumed (Lew et al., 2009). Smoking and drinking combined can put someone at a higher risk for cancer. The alcohol may act as a solvent that allows chemicals and byproducts of cigarette smoke to enter the cell lining and the digestive tract, slowing the ability of the cell to repair the DNA damage caused by smoking (American Cancer Society, 2013). The link between the use of substances during cancer therapy and an increased risk of cancer recurrence is less clear.

Temporal Sequencing of Partner Violence and Cancer

The body of literature does not clarify whether IPV can create an environment that predisposes women to developing malignancies. Victimized women have suggested that they felt the abuse could have caused the cancer (Sawin et al., 2009). Because of emotional and financial strain precipitated by a cancer diagnosis, one study suggested that women with cancer may become victims of IPV more often than others (Schmidt et al., 2006). Just as women experiencing IPV are less likely to engage in preventive health screening that could identify cancer in its most curable stage, women with cancer are not likely to be screened for or disclose abuse after a cancer diagnosis or during treatment (Canady, Naus, & Babcock, 2010).

Methods

The current study uses data from the first year of a seven-year prospective study funded by the Houston Endowment and approved by the institutional review board of Texas Woman’s University. The purpose of the overarching study is to investigate the treatment efficacy of the two most commonly used intervention models offered to women experiencing IPV (i.e., safe shelter and justice services). Justice services allow women to remain in the community through the acquisition of a protection order. Safe shelter relocates women to a shelter facility, often located far away from their neighborhoods, friends, and place of work. In addition, the study aimed to investigate the seven-year effects of abuse on women’s functioning and health outcomes, including the incidence of a cancer diagnosis. The overarching study also is tracking the development and well-being of the children of the women affected by abuse. However, data related to child health and functioning will not be presented in the current article. A detailed report of the seven-year prospective study is presented elsewhere (McFarlane, Nava, Gilroy, Paulson, & Maddoux, 2012). Instruments specific to the current study are described in Table 1.

Procedures

In line with the scope of the seven-year prospective study, participants were recruited through shelters and the justice system, which refers to the district attorney’s office in the Houston metropolitan area. As women reached out to use those services, research associates approached them with an overview of
the study, invited them to participate, and obtained informed consent. Once participants signed the consent form, research associates interviewed the women to get demographic and other key measurement data. The initial interview lasted about 45 minutes. In the seven-year prospective study, women are contacted and interviewed every four months. The current study used data from the 12-month interviews. To understand the level of functioning among women who experienced IPV and had been diagnosed with cancer, mean and standard deviation were calculated on outcome measures (see Table 2).

TABLE 1. Instruments Used to Measure Study Variables

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Description</th>
<th>Time to Administer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Pain Inventory</td>
<td>A self-report instrument used to quantify intensity, location, quality, and treatment of chronic pain, as well as its impact on daily life. A participant is to have recent chronic pain if it did not go away and lasted three months. The degree to which pain interferes with seven domains of functioning (i.e., general activity, mood, walking ability, normal work, relations with others, sleep, and enjoyment of life) is assessed using a scale ranging from 0 (does not interfere) to 10 (completely interferes). Scores are generated for severity of pain and interference of pain with activities of daily living.</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Brief Symptom Inventory (BSI)</td>
<td>The shortened 18-item version of the BSI-53 measures three global indicators of psychological distress (i.e., depression, anxiety, and somatization), with scores ranging from 0 (not at all) to 4 (extremely). Internal consistency reliability ranges from 0.74–0.89 on the subscales. Test-retest reliability over two weeks ranges from 0.68–0.91.</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Community Agency Use, Frequency, Helpfulness, and Difficulty</td>
<td>Assesses the use of nine different types of community agencies commonly used by abused women (e.g., battered woman’s counseling, shelter or emergency housing, legal intervention or services, faith community, social services, health care). A score of 0–9 is generated depending on the number of agencies used. If a woman indicates use of an agency, she is asked about frequency of use and how helpful the agency was in assisting with coping. A second set of questions asks whether the woman has tried to access any of the agencies and whether she experienced any difficulties doing so.</td>
<td>6 minutes</td>
</tr>
<tr>
<td>Danger Assessment Scale</td>
<td>A 19-item questionnaire that elicits a yes or no response and is designed to assist women in determining their potential risk for murder associated with intimate partner violence. Convergent construct validity has been supported by moderately strong correlations with other tools measuring severity and/or frequency of abuse. Reliability is 0.71 and ranged from 0.6–0.86 in five subsequent studies. Weighted scoring resulted in four ranges of danger (i.e., less than 8 was variable danger, 8–13 was increased danger, 14–17 was severe danger, and 18 or greater was extreme danger).</td>
<td>5 minutes</td>
</tr>
<tr>
<td>General Self-Efficacy Scale</td>
<td>A 10-item instrument used to assess the general sense of perceived self-efficacy in coping and adaptation after stressful life events. Scores range from 10–40. Criterion-related validity is documented in many correlation studies where positive coefficients were found with favorable emotions, and negative coefficients were found with depression, anxiety, and somatization. In studies from 23 countries, Cronbach alphas ranged from 0.76–0.9.</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Koci Marginality Index (KMI)</td>
<td>A five-item, abbreviated version of the KMI-95 and KMI-70 that uses a five-point Likert-type scale to assess women’s marginality, the perception of living on the periphery of the social center. Scores range from 0–25. In previous research, the internal consistency (Cronbach alpha coefficient) of the KMI-70 was 0.96 (n = 244).</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Norbeck Social Support</td>
<td>A well-established six-item instrument that measures multiple components of social support, including functional properties of social support, network properties, and the amount of support from specific individuals, with a network size up to 24. For the purposes of the current study, participants were asked for the initials of their three primary sources of support. An extra question followed the Norbeck standard questions that asked whether the abused woman shared their experience with their sources of support.</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD) Scale</td>
<td>A seven-item symptom scale that is a subset of items derived from the National Institute of Mental Health Diagnostic Interview Schedule for the Diagnostic and Statistical Manual of Mental Disorders. A score of four or greater defines a positive PTSD screen with a sensitivity of 80%, a specificity of 97%, a positive predictive value of 71%, and a negative predictive value of 98%.</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Safety Behavior Checklist</td>
<td>A seven-item safety checklist that assesses the present use of safety behaviors and documents intent to adopt future behaviors, which was initially published by the March of Dimes. Content validity was established by nurse researchers with expertise in the area of violence against women, and it has been used to evaluate the adoption of safety behaviors in the population of abused women. Scoring of the instrument takes into consideration the appropriateness of interventions for each woman, resulting in a score of 0–7 behaviors performed.</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Severity of Violence Against Women Scale</td>
<td>A 47-item instrument with nine subscales designed to measure threats of physical violence (19 items) and physical assault (28 items). The possible range of scores is 19–76 for the threats of abuse and 28–112 for physical assault. Internal consistency reliability for abused women ranges from 0.89–0.91 for threats of abuse and 0.91–0.94 for assault.</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>

Sample

A total of 300 women agreed to participate in the current study. Half (n = 150) of the total sample were recruited from the district attorney’s office, and the remaining half (n = 150) were recruited from various shelters. A subsample of women was created to describe the lives of women who experienced IPV and reported a diagnosis of cancer (n = 8). The eight women who reported a cancer diagnosis ranged in age from 27–42 years (X = 33.71 years, SD = 4.92). Five of the women sought assistance through the justice system, and three women sought safe shelter. The women were Caucasian, African American, or Hispanic (see Table 3).

Results

Of the 300 study participants, eight women reported a cancer diagnosis at some point in their lives. Specific malignancies identified were cervical cancer (n = 6), thyroid cancer (n = 1), and skin cancer (melanoma, n = 1) during the first year of the study. The incidence of cervical cancer in this relatively young study population is six cases per 300 women (2%). One of the women stated that she felt the cancer was a result of the stress she experienced because of the physical and emotional abuse she endured. All women in the study will be followed for six more years to determine whether additional cancers are identified.

Outcome measurements indicated that the eight women in the sample had experienced severe abuse and were at high risk for reabuse and additional victimization, as evidenced by threat scores, physical abuse scores, and danger assessment scores. In addition, the women in this sample appeared to be experiencing great psychological and physical distress. Those women evidenced psychological harm from their clinically meaningful scores with regard to PTSD symptoms, Brief Symptom Inventory (BSI) global scores, and BSI anxiety scores. Participants reported high levels of pain severity and pain interference, indicating physical effects from IPV. Many of the participants with or without cancer reported chronic pain, but the pain severity and pain interference of the cancer group was significantly higher.

Discussion

According to Surveillance, Epidemiology, and End Results (SEER) program data, the age-adjusted incidence is 8.1 per 100,000 for all U.S. women, with the median age at diagnosis for cancer of the cervix being 48 years (0.008% of the population) (National Cancer Institute, 2014). Those rates are based on cases diagnosed from 2004–2008 in 17 SEER geographic areas. The mean age of women in the current study sample was 34 years, suggesting that the age of diagnosis was below the average age of cancer detection in the United States. The current study is consistent with previous reports that cervical cancer is more prevalent and is diagnosed at an earlier age in women who have experienced IPV, when compared to the same age group in the general population.

Although no significant differences were found with regard to demographic or study variables, it should be noted that the
study shows the high levels of pain and distress women with cancer experience. Women who sought assistance for IPV by leaving home had higher marginality scores than the women who were able to stay at home with the aid of law enforcement and a protection order (see Table 4). That also is consistent with existing literature that indicates sheltered women may have weaker support systems and fewer resources than women who remain in the community (McFarlane et al., 2012).

The high threat scores, physical abuse scores, and danger assessment scores indicate the abused women with cancer are at high risk for continued abuse or revictimization regardless of whether they entered the system through safe shelter or justice services. The risk of revictimization is reduced when the woman is employed, has a strong social support system that provides practical help, has access to healthcare and social services, and perceives having a higher quality of life (Bybee & Sullivan, 2005). Women with cancer, however, may lack those protective mechanisms. As health deteriorates with a cancer diagnosis, disease progression, or treatment, women with cancer are less likely to be employed, and the perceived quality of life may deteriorate. Access to financial, healthcare, human, and other resources also may decline, making those women more vulnerable to new, continued, or renewed cycles of violence.

Limitations

The study methodology has limitations that may under- or over-represent abuse victims with cancer. Recruitment protocol did not seek or exclude women with cancer. Researchers relied on self-report of the women in the study to disclose a cancer diagnosis. No confirmatory diagnosis was made by a healthcare provider that was a member of the research team. The dates of cancer diagnoses provided by the women varied from five years prior to seeking assistance for the abuse to diagnoses that were made after entering the study. Because of the lack of preventive health care received by the women in this study, it is possible that other undiagnosed cancers are present in the sample.

TABLE 4. Comparison of Women Living in a Shelter Versus Living in the Community

<table>
<thead>
<tr>
<th>Identification</th>
<th>Type of Cancer</th>
<th>Safety Score</th>
<th>Self-Efficacy</th>
<th>Marginality</th>
<th>Age (Years)</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in a Shelter</td>
<td>Cervical</td>
<td>4</td>
<td>22</td>
<td>10</td>
<td>30</td>
<td>Hispanic</td>
</tr>
<tr>
<td>A</td>
<td>Cervical</td>
<td>4</td>
<td>33</td>
<td>9</td>
<td>34</td>
<td>Caucasian</td>
</tr>
<tr>
<td>B</td>
<td>Cervical</td>
<td>5</td>
<td>38</td>
<td>8</td>
<td>33</td>
<td>Caucasian</td>
</tr>
<tr>
<td>C</td>
<td>Cervical</td>
<td>4.34</td>
<td>31</td>
<td>9</td>
<td>32.34</td>
<td>–</td>
</tr>
<tr>
<td>Living in the Community</td>
<td>Cervical</td>
<td>3</td>
<td>37</td>
<td>16</td>
<td>34</td>
<td>Hispanic</td>
</tr>
<tr>
<td>D</td>
<td>Cervical</td>
<td>6</td>
<td>29</td>
<td>18</td>
<td>27</td>
<td>Hispanic</td>
</tr>
<tr>
<td>E</td>
<td>Cervical</td>
<td>2</td>
<td>25</td>
<td>12</td>
<td>38</td>
<td>African American</td>
</tr>
<tr>
<td>F</td>
<td>Skin</td>
<td>2</td>
<td>31</td>
<td>8</td>
<td>36</td>
<td>Caucasian</td>
</tr>
<tr>
<td>G</td>
<td>Thyroid</td>
<td>5</td>
<td>27</td>
<td>18</td>
<td>43</td>
<td>African American</td>
</tr>
<tr>
<td>H</td>
<td>Cervical</td>
<td>3.6</td>
<td>29.8</td>
<td>14.4</td>
<td>35.6</td>
<td>–</td>
</tr>
</tbody>
</table>

Implications for Practice

- Review, update, and develop institutional policies to screen all patients with cancer for intimate partner violence (IPV) on a regular basis.
- Ensure that information and resources are available to patients in the oncology setting who may be experiencing IPV.
- Provide education for nurses regarding therapeutic responses to patients who disclose abuse.

Implications for Nurses

Chronic stress, depression, lower self-efficacy, smoking, multiple intimate partners, sexual abuse, and childhood physical abuse are cited in the literature as contributing factors that lead to a higher incidence of cancer. Women in abusive relationships are less likely to receive preventive women’s healthcare services and may report feeling that the abuse may have caused the cancer. Because of emotional and financial strain precipitated by a cancer diagnosis, women with cancer also may become victims of IPV (Schmidt et al., 2006).

Evidence-based strategies are needed to place more emphasis on IPV screening in oncology care. Awareness of agencies’ and states’ policies regarding screening and reporting IPV is the first step in developing population-specific strategies to address the issue. Adding screening questions to oncology clinic forms, reinforcing the need to screen, providing privacy, and assuring confidentiality that facilitates disclosure of personal information, and reminders to document abuse assessments are critical actions that could help detect or prevent IPV (Owen-Smith et al., 2008).

IPV may be present in women from all backgrounds and ages. Even in old age and at the end of life, unresolved past abuse or current abuse should be identified and managed (World Health Organization, 2012). Palliative and hospice agencies provide excellent care for patients and their families facing a loss. Professional caregivers should consider the altered support networks and special needs of a family that has been affected by violence to aid patients in achieving some form of resolution before or at the end of life (Macpherson, 2009; Sawin & Parker, 2011).

Equipping oncology nurses with information and resources enables them to intervene most effectively when IPV is identified. Clearly stated policies that include hotline numbers, safety information, contact numbers for local shelters, and procedures for entering the justice system should be available in every clinic and to every nurse (see Figure 1). A well-developed plan and standardized follow-up would ensure consistent care for all women. Partnering with
other healthcare professionals and disciplines also is important. Offering to provide information to area hospitals, clinics, and agencies serving abused or potentially abused women and encouraging the inclusion of cancer screenings can help women who experienced IPV receive higher-quality health care (Hawley & Hawley Barker, 2012).

Additional research is needed to explore the links between cancer and IPV. The needs and thoughts of those women fighting two battles can provide evidence to help nurses provide informed and compassionate care for women with cancer who are also struggling to survive an abusive relationship.

Conclusion

A patient with cancer who has experienced IPV presents unique challenges for the oncology nurse. Recognition of who is at risk and implementation of sound policies once a disclosure has been made are crucial steps to improve the health, well-being, and outcomes of abused women who are being treated for cancer.

References


Futures Without Violence

Provides education programs, national policy development, professional training programs, and public actions designed to end violence against women, children, and families.

Phone: 415-678-5500

Website: www.futureswithoutviolence.org

National Coalition Against Domestic Violence Public Policy Office

A national leader in efforts to develop and influence federal and state legislation that positively affects the lives of domestic violence victims and their children.

Phone: 202-745-1211

Website: www.ncadv.org/publicpolicy/ThePublicPolicyOffice.php

National Domestic Violence Hotline

Confidential, 24/7 hotline that provides support, crisis intervention information, and referral services in more than 170 languages.

Phone: 800-799-7233 (TTY: 1-800-787-3224)

Website: www.th hotline.org

National Sexual Assault Hotline

Connects callers with counselors at the nearest Rape, Abuse, and Incest National Network member center.

Phone: 800-656-4673

Website: www.rainn.org/get-help/national-sexual-assault-hotline

National Teen Dating Abuse Hotline

A resource that works to engage, educate, and empower youth and young adults to prevent and end abusive relationships.

Phone: 866-311-9474 or text “loveis” to 22522

Website: www.lovesrespect.org

Office on Women’s Health

Information on women’s health issues, including cervical cancer and domestic violence, provided by the U.S. Department of Health and Human Services.

Phone: 800-994-9662

Website: www.womenshealth.gov

FIGURE 1. Resources for Preventing and Ending Intimate Partner Violence


