

Breast Cancer in the Context of Intimate Partner Violence: A Qualitative Study

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In the United States, approximately one in eight women (12.5%) will develop invasive breast cancer during her lifetime (Manne, Pape, Taylor, & Dougherty, 1999; National Cancer Institute, 2006). One in four women will experience intimate partner violence (IPV), such as physical assault, sexual assault, or stalking, during her lifetime (Coker et al., 2007a, 2007b; Tjaden & Thoennes, 2000). Although the exact rate is unknown, some women experience breast cancer and IPV simultaneously. Researchers have documented the importance of a positive partner response to a woman's ability to deal with breast cancer (Koopman, Hermanson, Diamond, Angell, & Spiegel, 1998; Manne & Badr, 2008; Manne & Glassman, 2000; Manne et al.; Pistrang & Barker, 1995; Sales, Schulz, & Biegel, 1992), but little attention has been paid to those who are dealing with breast cancer while in an abusive relationship.

Nearly half of women with breast cancer report changes in their relationships with their partners (Barni & Mondin, 1997), and some changes in health status, such as pregnancy or the presence of a physical disability, seem to make women more vulnerable to abuse and injury (Curry, Hassouneh-Phillips, & Johnston-Silverberg, 2001; Parker, McFarlane, & Soeken, 1994; Parker, McFarlane, Soeken, Silva, & Reel, 1999). However, little is known about how IPV and breast cancer interact.

Oncologists Schmidt, Woods, and Stewart (2006) noted multiple reports of IPV from patients in their oncology practice. Although noting the lack of literature on the topic, they posited that patients with cancer, like pregnant women and older patients, are members of a vulnerable population and are, therefore, at higher risk for IPV. They suspected that IPV prevalence is higher in patients with cancer but that practitioners, perhaps because they do not want to believe it happens in their practices, likely believe that the IPV rate is lower. Schmidt et al. noted that patients with cancer can become frail as a result of the disease and treatment effects, therefore increasing dependence on their caregivers as well as becoming at risk for social isolation because of physical changes. They argued that a cancer diagnosis could provide a unique "provocation of violence" against a patient with cancer because of the lack of control that the partner has over the cancer, as well as the

Purpose/Objectives: To describe the experiences of women who were diagnosed with breast cancer while also encountering intimate partner violence (IPV). IPV was determined by scores on the Women's Experience With Battering Scale and the Abuse Assessment Screen.

Research Approach: Qualitative interviews were conducted with a convenience sample of seven women. Data were analyzed with a hermeneutic phenomenologic approach.

Setting: Community settings in central Virginia and Maryland.

Participants: 7 participants ranging in age from 37–63 years (\bar{X} = 50 years); age at diagnosis ranged from 36–58 years (\bar{X} = 46 years). All were in relationships with men, and relationship length ranged from 2–29 years (\bar{X} = 12 years).

Methodologic Approach: Each participant had one semi-structured qualitative interview.

Main Research Variables: Experiences of women simultaneously experiencing breast cancer and IPV.

Findings: A number of themes emerged, including: (a) reassessing life, (b) believing that stress from the relationship caused the cancer, (c) valuing support from others, and (d) the significance of the breast.

Conclusions: For all of the participants, the breast cancer diagnosis changed their intimate relationships in some way. The cancer was an opportunity for the women to engage in life review, focus inward, and, in some cases, change the relationship status.

Interpretation: Increased awareness and screening for IPV are needed in oncology clinical settings. Women with cancer are members of a vulnerable population and use the diagnosis to reassess their intimate relationships.

possibility of abandonment that cancer poses (Schmidt et al., p. 26). Taylor-Brown, Kilpatrick, Maunsell, and Dorval (2000) explored the popular belief of partner abandonment of women with breast cancer in a review of the literature. They determined that no increased risk exists for women. That assertion, however, was based on a single study of marital satisfaction, wherein the participants, who had already been participants in a quality-of-life study, were not screened for abuse. The authors acknowledged the possibility that abusive relationships may have existed and used examples from clinical practice.

A few researchers have studied IPV and cancer. Onishi et al. (2005) studied three women with post-traumatic stress disorder (PTSD) related to physical and emotional abuse from their husbands while being treated for cancer, and the researchers concluded that women with cancer should be screened for aggressive violence as part of cancer treatment. Patients with cancer with a history of childhood sexual, physical, or emotional abuse have a higher likelihood of emotional difficulties with breast cancer surgery, including emotional distress, post-traumatic stress, bodily shame, and self-blame (Salmon et al., 2006). Childhood sexual abuse and sexual violence have been associated with lower rates of screening for cervical cancer and breast cancer (Farley, Golding, & Minkoff, 2002; Farley, Minkoff, & Barkan, 2002). IPV has been a barrier to mammography screening in African American women (Moy, Park, Feibelmann, Chiang, & Weissman, 2006). However, little information exists on what it is like to have breast cancer and live in a violent situation. Therefore, this qualitative study used a hermeneutic phenomenologic approach to explore the experiences of women who simultaneously experienced IPV and breast cancer.

Methods

Participants

Following institutional review board approval, a convenience sample of seven women with breast cancer was recruited by advertisements in local newspapers inviting participation from women who were in a “difficult or troubled relationship at the time of a breast cancer diagnosis.” The wording was selected from the authors’ experience that women are reluctant to identify themselves as abused. Participants were located primarily in central Virginia and Maryland. Recruitment lasted for three months, and saturation was not achieved. All women gave informed consent.

IPV was defined as “a process whereby one member of an intimate relationship experiences vulnerability, loss of power and control, and entrapment as a consequence of the other member’s exercise of power through the patterned use of physical, sexual, psychological, and/or moral force” (Smith, Smith, & Earp, 1999, p. 186). For the purposes of this article, IPV and abusive intimate relationship are used interchangeably. The definition was operationalized by scores on the Women’s Experience With Battering Scale (WEB) and the Abuse Assessment Screen (AAS) (Parker & McFarlane, 1991; Smith, Earp, & DeVellis, 1995). Both instruments have been used with women whose characteristics are like those in this sample. All of the women who self-identified as abused met the inclusion criteria, which was having a score indicating abuse on either of the instruments.

The WEB measures the psychological vulnerability that abused women experience, especially in the areas of mental health, anxiety, and depression (Smith, Earp,

et al., 1995; Smith et al., 1999; Smith, Tessaro, & Earp, 1995). The WEB is a 10-item scale with scores ranging from 10–60. A score of 19 or higher is definitive of abuse as derived from a sensitivity and specificity analysis, resulting in a sensitivity of 94.6% and a specificity of 96.1% (Smith, Earp, et al.). Cronbach’s alpha was reported as 0.86–0.99. The researchers determined validity by comparing mean scores of known abused women and not abused women and by correlating scores with variables known to be associated with battering, such as physical abuse ($r = 0.71$) and psychological abuse ($r = 0.88$) (Smith, Earp, et al.).

The Nursing Research Consortium on Violence Against Women developed the AAS by modifying a screening tool created by Helton (1987). For the current study, the three-question version was used, as shown in Figure 1 (pregnancy questions omitted). The AAS has been used extensively as a clinical screening tool as well as a measurement to identify abused women in comparative studies. In the version used by the researchers, an affirmative answer to question 2 or question 3 is indicative of abuse. The AAS has been used in several studies. McFarlane, Parker, Soeken, and Bullock (1992); Parker et al. (1994, 1999); and Soeken, McFarlane, Parker, and Lominack (1998) described the psychometric properties of the AAS by recruiting an ethnically stratified sample of 280 pregnant women who reported abuse on the AAS and comparing them to a random sample of 280 women not reporting abuse. Test-retest reliability with two subsamples of 48 and 40 women in that study was 0.83 and 0.975, respectively. Discriminant group validity was established by comparison of the scores of the two groups of women on the Index of Spouse Abuse, the violence subscales of the Conflict Tactics Scale, and the Danger Assessment. Significant differences ($p < 0.01$) were found between the two groups on all measures, indicating that the AAS was able to differentiate between abused and not abused women. Construct validity was supported by significant and moderately strong correlations with all three research instruments (McFarlane et al., 1992).

Data Collection

Data were collected with semistructured interviews. The interviews were recorded on audiotape and lasted an average of 60 minutes. The participants selected the interview sites, such as their homes, places of employment,

- Have you ever been physically abused by someone important to you? (Yes or no?) Who?
- In the past year, have you been pushed, slapped, hit, kicked, or otherwise physically hurt by your partner or ex-partner? (Yes or no?) Who?
- In the past year, did anyone force you to have sexual activities you did not want? (Yes or no?) Who?

Figure 1. Abuse Assessment Screen

Note. Based on information from Parker & McFarlane, 1991.

conference rooms at the school of nursing, or over the telephone. Sample questions are included in Figure 2.

Data Analysis

Trained professionals certified in the Health Insurance Portability and Accountability Act transcribed the interviews. The data were analyzed with a hermeneutic phenomenologic approach (Cohen, Kahn, & Steeves, 2000). In hermeneutic phenomenology, the researcher analyzes and interprets the narratives of those who have experienced a phenomenon first-hand to gain understanding of that lived experience (Van Manen, 1990). The researchers analyzed and reanalyzed the data to identify themes that characterized the experiences of the participants. First, natural meaning units (i.e., phrases, sentences, or paragraphs deemed to be potentially relevant for eventual theme development) were identified in the interviews. The units then were grouped into categories and coded based on perceived similarities. The first level of coding produced categories that remained very close to the interview data. The next stage of analysis involved grouping the categories into themes that represented the experiences of the participants and addressed the specific aim. The interview audiotapes were destroyed after transcription according to protocol. The research team discussed the interviews in weekly meetings. The team kept an audit trail and consulted a peer reviewer, a qualitative expert.

Results

Description of Sample

The seven participants ranged in age from 37–63 years ($\bar{X} = 50$ years) at the time of the interviews; age at diagnosis ranged from 36–58 years ($\bar{X} = 46$ years). The amount of time between diagnosis and interview ranged from 1–11 years ($\bar{X} = 4.6$ years). Six of the women were Caucasian and one was African American. All were in relationships with men, and the length of the relationships ranged from 2–29 years, with a mean of 12 years. Their WEB scores ranged from 30–60 ($\bar{X} = 45$). A score of 19 or higher indicates abuse.

The women's cancer ranged from stages I–III. Three women had lumpectomies and four had mastectomies, one of them elective. Three of the women mentioned a strong family history of gynecologic cancer; two had sisters who died of breast cancer, and one had a sister who died from ovarian cancer. One woman, who had watched her sister die of ovarian cancer, noted, "(I) knew what I was in for," leading her to tell her boyfriend that it would be okay with her if he wanted to take a break from the relationship while she was undergoing chemotherapy.

The women experienced a variety of types of abuse. One woman stated that her partner abandoned her. He left the country with his mistress when the participant was beginning chemotherapy. Another woman de-

- Can you tell me a little about your partner and your relationship?
- Tell me about the breast cancer.
- How did you learn about the cancer?
- What kinds of treatments have you had?
- How did you tell your partner about the initial diagnosis?
- What was his response?
- How did you tell your partner about the treatments?
- Have you had a lot of side effects from the treatment?
- Do you think that the breast cancer has changed your relationship with your partner in any way? If so, how?
- Is there anything you wanted or needed from your partner that you did not get?

Figure 2. Sample Interview Questions

scribed "abuse by neglect," abuse by "acts of omission rather than commission. . . . He was totally unresponsive." One partner's behavior was emotionally abusive; he hid things and lied to her repeatedly. "There wasn't physical abuse; he [expletive] with my head."

Other men were physically abusive. One woman's husband, not normally a clumsy person, repeatedly "accidentally" knocked into her, including knocking into her breast following a biopsy. Another woman's husband, who had been verbally abusive for many years, became physically abusive after their separation, pushing her down the stairs and kicking her. He later obtained a restraining order, charging her with attacking him. Another boyfriend got "rough" during alcohol-induced arguments, apologizing profusely later. After the woman broke up with him, he tried to come back to her and beat her up when she refused him. "It was two days after chemo, and I didn't have much to fight back with."

One woman's relationship contained verbal and sexual abuse. After her discharge from the hospital, her partner insisted on having sex immediately and frequently woke her up in the middle of the night for sex. He harassed her after she broke up with him, sometimes calling her 50–60 times per day. Four of the men had affairs while the participants were undergoing breast cancer treatment.

All of the women reported a change in their partner relationships because of their breast cancer diagnoses, but the relationship changes took various forms. For two women, having breast cancer led them to decide to seek counseling for themselves, their partners, and their relationships while remaining with their partners. One woman with a young daughter chose to divorce her husband. Two women broke up with their boyfriends, enduring subsequent harassment and physical violence, and another woman with a long-term, live-in boyfriend had to "force him" out of their house. One woman's husband left her when he found out that she would have to have a mastectomy. Two of the women obtained restraining orders at the end of their relationships.

Themes

Reassessing life: The diagnosis of breast cancer often was a key event in reassessing life and re-evaluating

relationships. Life review after a cancer diagnosis is common (Taylor-Brown et al., 2000); for six of these women, it included reassessing their relationships. The combination of an abusive partner and a breast cancer diagnosis led several women to leave their partners or begin counseling. For example, one woman said that the breast cancer diagnosis was a “blessing” because it forced her to confront her husband about his behavior and to adopt a more healthful lifestyle.

I set myself on a course of making sure that I was really looking after myself in ways that I hadn't been, and it put my husband, who had been incapable of being supportive, in confrontation with his limitations as well. . . . I had to decide if I was going to always be a victim and to decide if I was going to learn that looking after myself, even if no one else gave a damn about me, was enough. . . . I was in a position where I had to start standing up for myself. I told my husband, “If you can't help me, just at least get out of my way and leave me alone.”

Another woman reassessed her life and decided to avoid the negative.

[Breast cancer] caused me to live my life differently and to minimize my contact with [my husband] because my contact was always so negative and so disturbing. . . . It made me change my life. It made me realize that this can come back and I might die, and I had to really rethink how I wanted to organize the rest of my life.

She described the diagnosis as,

A whack over the head or a punch in the stomach that makes you not take another step forward until you know which direction you're going in, until you know you can walk in a different direction. You can't keep going in the one you were going in because that one's going to cause you even more damage than you've already incurred.

Echoed another participant,

He wasted some of my precious lifetime, and after the cancer, that really became inexcusable. I pissed away my time before the breast cancer. I took time for granted. I took my life . . . all of that, and then when you have a life threat, all that is in jeopardy.

One woman cited an observation that she made while in her breast cancer support group that was a life reassessment and the deciding factor for her breakup.

There was a woman who was in a very stressful relationship; she had step-kids and she was talking about how stressed she was, and she was five years out, kept having recurrences, and I sat across from her and thought, “That's going to be me if I stay in this relationship.” And I thought, “If she stays in that relationship, she's going to end up dead.” She

actually died on Christmas Eve, and that had the biggest impact on me.

For one woman, the reassessment that came with having cancer accelerated the breakup of a relationship that probably would have soured eventually.

I think that if there had been no cancer involved, we eventually would have realized that we were probably not for each other, but it wouldn't have been so abrupt. It definitely proved his need [for] . . . beautiful women, the prettier the better. He had an issue with people who didn't look the way you're supposed to look.

Believing that stress from the relationship caused the cancer: A long-standing debate has occurred about the role of stress in cancer development and progression (Price et al., 2001). Despite inconclusive evidence that stress causes cancer, many people believe that stress is a risk factor for breast cancer development. Many of the women in the current study believed that the stress of their abusive relationships caused the cancer or would cause it to worsen or recur.

I've had to cut way back on the stress because I think the stress was a factor, and that's what my doctor told me, too. She thinks that the stress brought it on. She said there is absolutely no clinical evidence to support that opinion, but that's her view; she says she sees patient after patient whose stress level becomes incredibly high but they don't leave [an intimate partner] because of the children. They don't do anything because of the children. They put up with [abuse], which is what I did, and then they come in with a diagnosis of breast cancer.

Said another woman in the study,

I was really stressed all the time, and so I started seeing a therapist because I was under so much stress. I felt exhausted all of the time, I felt that something was taking a toll on my body physically with my [abusive] relationship, and then I went for a mammogram. . . . And when I was diagnosed, I really wasn't surprised, just because I knew it was taking a toll on me physically. A little over two years of that constant stress in your body, it takes a toll on you. . . . I definitely think that there was a correlation between the two [the stress of IPV and breast cancer].

Another woman had a history of multiple violent relationships, in addition to her current relationship, which she described as “extremely violent.” She said, “My father was violent as well, so which relationship do we attribute this ultimate outcome [breast cancer] to? I'm not sure, but there's definitely a correlation I feel.”

One woman's participation in a breast cancer support group caused her to be able to compare the progress of women in stressful relationships to women in supportive relationships.

And the interesting part about that group, there's two women that regularly go, they were diagnosed five years ago and both have supportive husbands, they've never had a recurrence. . . . I don't think it's a coincidence that the one woman who was stressed, you know, kept having recurrences every year since she's been diagnosed, ended up dead.

Valuing support from others: High-quality social support has been shown to increase quality of life in patients with cancer (Turner-Cobb, Sephton, Koopman, Blake-Mortimer, & Spiegel, 2000), and the support does not necessarily have to come from a partner. However, many patients identify their partners as their most valuable sources of support during the cancer experience (Koopman et al., 1998; Pistrang & Barker, 1995), and overall relationship quality affects the way a woman adjusts to her breast cancer diagnosis (Dorval et al., 2005; Koopman et al.; Manne & Badr, 2008; Manne & Glassman, 2000; Pistrang & Barker).

Positive support was mentioned, in the form of support groups, family, friends, or therapists, but not intimate partners. For some of the women, adult children were an important source of support. "My kids came and started helping me at home because I was real weak." Another woman's daughter accompanied her to all of her treatments. Support groups also were helpful for some women because, "I wasn't the only one with one breast. . . . We [were] all talking about it. . . . It was flushing things out loud, not holding that garbage." One participant talked about the importance of nurses who are working with women who have had breast cancer.

I had a lot of nurses that tried to help me with my self-esteem and build it back up, my confidence, you know what I'm saying, and I went through counseling to . . . try to make me feel better about myself. And they helped me out. They talked to me; I did a lot of crying, I did a whole lot of crying. And I felt ugly, but they made me feel like I was going to be okay and I was a pretty person . . . 'cause I had a nice attitude. And they were very good, and that hospital was there for me.

It is difficult to know whether having a supportive partner would have affected those other sources of support. In some instances, the lack of social support was attributed, in part, to the intimate partner. One participant who had recently moved because of her intimate partner's job said, "We didn't know anyone, we didn't know how even to find any kind of service, somebody to talk to, none of that. . . . I had no support . . . really, truly." A woman who separated from her husband during her treatment stated, "It didn't sound like it was going to be that bad, but it was hard. So my neighbor helped me out a little bit, but mostly I did it all myself." She described the long-term effects of her partner's lack of support.

I just didn't really come out of it. I never came out of it, I never got my strength back; I'm not the same person I was. The only thing that really kept me going was (knowing) that if I didn't survive he would have custody of her [their daughter], and that was scarier than anything, 'cause I can't imagine what would have happened to her; she would have been like homeless. And that's what still keeps me going, causes me to take care of myself.

Another woman noted, "I don't have family; I don't have anybody. My sister died of cancer, and my father died of cancer. . . . So [my boyfriend] was the person that was there." This woman's boyfriend prevented her from getting together with her friends at a local bar where he was a bartender because he was embarrassed at her appearance following chemo.

Significance of the breast: Breast cancer is distinctive because of the unique impact that it has on sexuality, self-esteem, and body image (Derogatis, 1986). Most of the women mentioned issues regarding gender in their interviews, citing the significance of the breast as the site of their cancer. One woman, although not talking about the violence from her intimate partner directly, spoke of the cancer as if it were another assault to her sexuality and gender.

It comes right down to what being a woman is and what having breasts is all about, and one of the major, major parts of it is nurturing. . . . The female breast is so, it's so visible, it's so tied to how we are seen in the world, it is so tied to how we are responded to as women, as sexual beings, as sexual objects, as mothers, as caregivers. I had a friend who was undergoing breast cancer treatment who said, "No man, even though they do have breasts, somewhat, can understand what this is like for a woman, what an assault it feels like. It does feel like an assault until you process it and then learn that you're not having an assault when you're having a lumpectomy . . . it is to help." But it was interesting that she used that word.

One woman, who kept the identity of her child's father a secret for more than 20 years, believed that the secret literally became malignant and caused her breast cancer. She noted that she had "a lot of self-hatred" relating to "the whole situation with mothering, and in having my daughter," and that it caused her to have "a lot of negativity going into [her breast]."

One woman's husband left her because the cancer was in her breast. "You know, he was a breast [man]; he liked breasts, you know. And he kind of felt like he couldn't do his job with one breast. So he left me."

Alterations in body image are common for women with breast cancer, and this came through in the interviews. One woman used the story of a woman from her support group to illustrate how alterations in body image play out in an intimate relationship.

One of the women, in a beautiful marriage, had to sleep with the turtleneck and the wig and the makeup on. She couldn't even go to bed without all this clothing on to hide the lines from the radiation, and it upset her husband if he saw her scar and the wig and the makeup. She says, "It takes me an hour to get ready just to go to bed." Because he can't look at her.

One participant's boyfriend was embarrassed by her hairlessness during chemotherapy: "I mean, this is the worst trick that can be played on a woman . . . los[ing] their hair, or especially losing a breast. . . . You've got to decide, 'What am I going to be with just one breast?'"

Discussion

These women recounted their experiences of simultaneously dealing with IPV and breast cancer. Some of the ways that the women dealt with the diagnosis were not unique to women in abusive relationships. For instance, adopting healthy self-care practices and engaging in life review are common to many who face a life-threatening diagnosis (Demark-Wahnefried, Aziz, Rowland, & Pinto, 2005; Kleinman, 1988; Taylor-Brown et al., 2000). The participants described alterations in body image, which are reported by nonabused women as well, but the extent to which this may differ for abused women is only beginning to be apparent. Many women with breast cancer seek meaning in and an explanation for breast cancer, and stress is a culturally popular culprit (Price et al., 2001). For this group, a unifying stressor was abusive intimate partner relationships. Also in common with many nonabused women, all of the women reported that the cancer diagnosis changed their relationships in some way.

What is striking about this small sample was that for four of the seven women, the cancer diagnosis prompted them to leave their abusive partners, turning around the popular notion of partner abandonment (Taylor-Brown et al., 2000). Leaving the relationships increased vulnerability for the women in the study, financial stress for some, worries about child custody for others, and even increased levels of violence (e.g., development of physical violence in what had been an emotionally abusive relationship, causing several women to seek restraining orders).

Researchers have noted that nearly one-third of women are assaulted—sometimes more violently—after ending a violent relationship (Fleury, Sullivan, & Bybee, 2000; Sleutel, 1998; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003). This supports the assertion of Schmidt et al. (2006), who posited that abused women with cancer are members of a vulnerable population.

Limitations of the current study include a small and relatively homogeneous sample. Also, data collection lasted for three months, and saturation was not achieved. In future studies, researchers should include

more postmenopausal women, minority women, and lesbians. Future studies should attempt to include women whose diagnosis or treatment was delayed or prevented by an abusive partner. Additional research questions should include direct inquiries into abuse history, both when women were children and during their previous adult relationships.

Implications for Nursing

Oncology nursing clinicians must acknowledge that patients with cancer may be experiencing IPV simultaneously and that helping patients deal with IPV and the physical realities of a cancer diagnosis is important (Mick, 2006). This study shows the importance of screening women for IPV of all types (physical, sexual, and psychological) because none of the women in this study reported being asked about IPV during the cancer experience. Oncology care providers could play an important role in identifying and referring patients who are experiencing IPV, as well as preventing IPV in some women (Mick). The AAS and WEB could be useful screening tools in the clinical setting.

Other considerations for clinicians include the fact that IPV can take many forms. Oncology professionals should be aware of the ways that IPV might affect a woman's experience with breast cancer and vice versa. They should not assume that a patient's partner is supportive and should be aware that a nonsupportive (not necessarily abusive) partner negatively affects a woman's ability to adjust to a breast cancer diagnosis (Pistrang & Barker, 1995). Healthcare providers also should remember that patients with cancer are members of a vulnerable population, and this can affect the level of violence in their lives (Hara & Rose, 2006). The increased stress, vulnerability, and upheaval experienced by such women serve as vivid reminders of the need for IPV screening and targeted assessment of partner support in oncology settings.

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