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FEATURE ARTICLE

Identifying Signs and Symptoms of Intimate Partner Violence in an Oncology Setting

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Domestic violence (DV), or intimate partner violence (IPV), is a prevailing problem in public health. Often, healthcare providers may be the first people that victims of DV will approach to reveal their problem or seek assistance. IPV is a pattern of control using assault and intimidating behaviors that has devastating effects on individuals, their families, and communities. Oncology nurses need to become familiar with common indicators of DV so that signs and symptoms of abuse can be identified when assessing patients in an oncology setting. Standards of oncology nursing practice support that the psychosocial impact of cancer on patients and their families or significant others needs to be considered at all stages of diagnosis and treatment. The psychosocial impact of other personal situations or concerns, such as IPV, can add to the complexity of cancer management. Routine screening for signs and symptoms of psychosocial distress helps identify patients who require additional interventions. Oncology nursing practice is based on a holistic approach to patient care, which supports that identification of physical and psychosocial needs are equally important. Oncology nursing provides many unique opportunities to help patients cope with cancer. Routine nursing assessment for signs and symptoms of abuse will provide an opportunity to assist patients with cancer to manage not only the life-threatening aspects of their diagnosis but also the life-threatening aspects of IPV.

Domestic violence (DV), or intimate partner violence (IPV), is a prevailing problem in public health (Family Violence Prevention Fund, 2004). IPV is a pattern of control using assault and intimidating behaviors that has devastating effects on individuals, their families, and communities (Family Violence Law Center, 2005). Standards of oncology nursing practice support that the psychosocial impact of cancer on patients and their families or significant others needs to be considered at all stages of diagnosis and treatment (Brant & Wickham, 2004; Harvey, 2003). The psychosocial impact of patients’ personal situations or concerns can add to the complexity of cancer management. For example, patients living with DV may face multiple challenges as they manage the stress of an additional life-threatening experience with the diagnosis of cancer. Oncology nurses need to become familiar with common indicators of DV so that signs and symptoms of abuse can be identified when assessing patients in an oncology setting.

An individualized plan of care must address all of patients’ identified psychosocial concerns to ensure optimal outcomes. Routine screening for signs and symptoms of psychosocial distress helps to identify patients who require additional interventions. Nursing care involves providing informational and emotional support in response to each identified concern (Fitch, 1999). Identification of IPV may be difficult because of

At a Glance

✦ Learning about intimate partner violence (IPV) can help oncology nurses identify and distinguish between signs and symptoms of abuse and cancer treatment side effects that may mask abuse.

✦ The holistic care approach of oncology nursing practice enables nurses to assess for the presence of IPV and provide informational and emotional support resources in response to patients’ identified concerns.

✦ Routine assessment for signs and symptoms of IPV provides a unique opportunity for oncology nurses to assist patients in managing any complex, life-threatening aspects of abuse that they may experience during cancer treatment.
ambiguous or unclear physical signs. Learning more about IPV can help nurses identify potential abusive situations so that appropriate interventions can be offered (Advance for Nurses, 2005; National Guideline Clearinghouse, 2005).

DV includes physical injury, psychological abuse, progressive social isolation, stalking, deprivation, intimidation, threats, sexual assault, and economic control perpetrated by someone who is, was, or desires to be involved in an intimate or dating relationship with an individual (Family Violence Prevention Fund, 2004). DV can involve partners of the opposite or same sex in any culture and any social class (National Center for Injury Prevention and Control, 2005). DV by men against women is made public more often, but the literature acknowledges that violence by women against men also occurs (Caetano, Schafer, Field, & Nelson, 2002; Cook, 1997; Corry & Fiebert, 2001; George, 2003; Healthy People 2010, 2005).

The most obvious signs of DV are evidence of severe, recurring, or life-threatening physical abuse (American Bar Association Commission on DV, 2005). However, assessment of more subtle or indirect signs often is necessary to identify IPV appropriately. For example, observations of fear, such as a visual appearance of distress, hand or voice tremors, lack of eye contact, and visible shaking, flinching, or showing signs that they are uncomfortable when being touched during an examination are indicators of the possibility of IPV. Another sign of potential IPV is the observation of partners who seem overprotective, control or dominate the assessment interview, and refuse to leave patients alone with healthcare providers during clinical examinations. Patients may seem overly anxious while they are being assessed with their partners present (Fleck-Henderson, 2004).

Role of the Healthcare System

The healthcare system plays an important role in identifying and preventing public health problems. Often, a healthcare provider may be the first person that victims of DV will approach to reveal their problem or to seek assistance. Studies in primary care settings revealed that 3.4%–5.5% of patients have experienced violence in the past year, with 21%–37% of the female population experiencing abuse at some point in their lives (Family Violence Prevention Fund, 2004). The trusting relationships that patients establish with healthcare professionals can make identifying and documenting patterns of abuse easier. Healthcare professionals can help by routinely asking about abuse during assessments, by remaining nonjudgmental when a situation of IPV is identified, and by offering information on resources and safety planning (Group Health Incorporated, 2005; National Guideline Clearinghouse, 2005). Helping patients to identify interventions in situations of IPV is just as important as helping patients and their families or significant others cope with the emotional and practical concerns that accompany a diagnosis of cancer and effects of cancer treatment.

Healthcare providers need to be aware of state statutes about DV because laws can vary from state to state. Many states mandate reporting of injuries caused in violation of criminal laws, such as violence or nonaccidental injuries. Some states specifically address required reporting of IPV. Becoming familiar with local DV resources, increasing understanding about how a local law enforcement agency responds to IPV, and knowing that referrals for police assistance do help victims of DV can greatly improve healthcare providers’ ability to assist patients (Family Violence Prevention Fund, 2004; Willson, McFarlane, Lemmey, & Malecha, 2001).

Mrs. G

Mrs. G, a 55-year-old woman diagnosed with breast cancer, arrived at the clinic waiting room for a follow-up appointment after completing her second chemotherapy treatment. As her name was called to report for her appointment, the nurse observed Mr. G lean toward and speak to Mrs. G and noted her fearful expression in response to what was said. Mr. G then held Mrs. G’s upper arm as they walked to the examination room. Each time the nurse asked an assessment question, Mrs. G lowered her eyes and Mr. G responded. When Mr. G was asked if he would step outside the room for a few minutes while the nurse completed the physical examination, Mr. G stated that he did not want to leave the room and insisted he should remain with his wife during her examination.

A healthcare provider’s assessment and response to signs of IPV are important to patients’ present and future safety and well-being (Family Violence Prevention Fund, 2004). Providing appropriate care and intervention may be challenging when partners insist on remaining with patients. Informing partners about policy or asking patients in the presence of their partners if they want the partner to leave the examination room can openly challenge partners’ control and may place patients at greater risk. Partners who suspect or discover that patients have sought care for IPV may retaliate with further violence. Therefore, when partners remain present for an examination, nurses should defer asking questions about IPV because such action can lead to additional abuse or retaliation for any comments patients may make (National Guideline Clearinghouse, 2005).

Inappropriate disclosure of health information may violate confidentiality and threaten patient safety. If obtaining privacy is difficult because partners refuse to leave the examination room, providers need to attempt to create a situation to be alone with patients so they can ask questions about possible abuse and can offer information about safety. For example, having another nurse continue to interview a partner while walking a patient to the bathroom to obtain a specimen may create an opportunity for the nurse to inquire about the patient’s situation, assess safety, and provide information about IPV and available resources. Maintaining a working relationship with partners, yet creating an opportunity for patients to ask questions or learn about resources, helps to achieve or maintain safety and can improve patients’ outcomes. If patients deny IPV but healthcare providers believe that they may be at risk, nurses should discuss the specific risk factors they have identified that created concern and offer information and available resources (National Guideline Clearinghouse, 2005).

Ms. K

Signs of abuse are not always obvious; however, a careful assessment can reveal evidence or symptoms of emotional, psychological, or physical abuse. When performing a physical assessment, all skin surfaces should be examined. Injuries caused by physical
abuse commonly are found in areas covered by undergarments, and burns, bruises, and/or scars may be in various stages of healing. Multiple or bilateral injuries, symmetrical bruising, pattern injuries, or bruises with an obvious shape should initiate further inquiry about their cause as well as an assessment of patients’ plans for safety. The primary responsibility for healthcare providers includes identifying and acknowledging abuse, providing sensitive support, documenting the abuse, and providing referral and resource information. The assessment of physical injuries should be documented, using a body map whenever possible. All patient statements about the injuries should be documented in the medical record as quotations. Proper documentation is critical in the event that a victim chooses to take legal action (National Guideline Clearinghouse, 2005).

While performing the preoperative assessment of Ms. K, a 22-year-old single woman diagnosed with cervical cancer, the nurse noted several bruises and scratches on her back and abdomen that were in various stages of healing. A similar pattern of bruising was observed on both sides of her neck.

The nurse let the patient know that she had cared for other patients with similar injuries that had been caused by someone hurting them. The nurse asked Ms. K if this might be the cause of her bruises; however, Ms. K became anxious and stated she “got a lot of scratches and bruises when she fell while doing yard work.”

Providers must remain nonjudgmental but be suspicious of abuse if inconsistencies exist between patients’ stated causes of injuries and actual injuries present. Victims of abuse may make excuses for abusers, sometimes out of fear or embarrassment. Abusers maintain control by frightening or harming victims, so patients who have been abused experience a loss of control. Although they may desire assistance, they often have fears regarding safety. Labeling the injuries as caused by DV or abuse before patients are ready to acknowledge their situation can cause them to stop seeking help.

Healthcare providers should express concern for patients’ safety and offer assistance in a supportive, empowering manner that prevents patients from feeling pressured to initiate steps that they are not comfortable with or ready to take. Increasing patients’ basic knowledge about IPV can assist them with safety planning and provide support for them to make informed decisions. By asking for patients’ consent, explaining each step of the plan of care, and providing information and the opportunity to use available resources, nurses support that decision making is returned to patients’ control (Fleck-Henderson, 2004).

Victims of abuse can benefit from learning about physical and emotional abuse. Victims may not realize that they are being abused. Healthcare providers must approach victims of IPV in a nonjudgmental and reassuring manner by validating their experiences while maintaining safety and privacy (National Guideline Clearinghouse, 2005). Patient education should be initiated by giving only the information patients can handle at the time. Nurses should include information about the cycle of violence, the effects of battering on children and family members, and how abusers use power and control; they also should affirm that no one deserves to be abused. Statistics and details can be overwhelming, so providing basic information about DV, assisting patients to realize they are not alone, and assisting them with developing a safety plan is often the most effective approach.

Mrs. L

Abuse can be physical, sexual, emotional, social, or economic. When a partner is frightened or harmed and the incident is part of a pattern in which the abuser uses power to frighten or harm the victim, it is considered abuse, regardless of whether physical contact occurs (Fleck-Henderson, 2004). DV includes slaps; pushes; shoves; threats; false imprisonment; verbal, emotional, or financial abuse; or any other behaviors used to control and coerce partners, such as making them request permission to do things. Emotional abuse includes continual degrading or belittling, such as stating that the partner is stupid, unattractive, a bad mother or father, unfaithful, overweight, or any other real or devised fault(s) (American Bar Association Commission on DV, 2005).

In addition to physical injuries that occur during an episode of violence, physical and psychological abuse have other adverse medical health effects. Victims of abuse often access healthcare services frequently and complain of more symptoms or health conditions than nonabused people do (Willson, Cesario, et al., 2001). During assessment, patients may complain of vague or chronic conditions, such as neck or back pain, headaches, or pelvic pain. Gastrointestinal symptoms may include complaints of frequent indigestion, diarrhea, constipation, peptic ulcers, and irritable bowel syndrome. A flat affect, complaints of chronic fatigue, significant weight loss or gain, insomnia, depression, suicidal ideation, low self-esteem, and other vague somatic symptoms also may be indicators of prolonged stress caused by abuse (Family Violence Prevention Fund, 2004; National Center for Injury Prevention and Control, 2005).

In an oncology setting, patients often experience treatment side effects that may mask symptoms of IPV. For example, when Mrs. L, a 62-year-old married woman with colon cancer, arrived at the outpatient center for her six-month follow-up appointment, the nurse noted her flat affect and statements about experiencing extreme fatigue. Patients with cancer undergoing treatments often may experience acute or chronic fatigue. Mrs. L also complained of backaches, headaches, digestive problems, anxiety, restlessness, and problems sleeping. Many chemotherapeutic medications can cause gastrointestinal symptoms. Bruising or bleeding can be attributed to anemia or thrombocytopenia. However, when the nurse asked screening questions for IPV, Mrs. L confused that sometimes her husband’s behavior “frightened her” but he had never been physically violent. Without use of a routine screening tool, Mrs. L’s symptoms may have been diagnosed as treatment related instead of providing insight about her abusive relationship.

Healthcare providers must understand that only victims can know the right time to leave a relationship, because they know the abuser better than anyone else. Even though they do not have control over the violence in their lives, many victims develop methods or routines to remain as safe as possible. Victims of abuse may make decisions or do things that they dislike or feel bad about that seem wrong or “crazy” to others who do not know the details of their situation. Often, risks are involved with leaving, including economic and social consequences and a loss of what was valued in the relationship for victims or their children. Deciding to leave an abusive partner and the act of leaving increases the risk of violence, so planning for safety during that
period of time is extremely important (Fleck-Henderson, 2004; National Center for Injury Prevention and Control, 2005).

Some people who are dealing with violent relationships do not define or interpret their situations as abuse or DV. Labeling relationships as domestic abuse or violence before patients are ready to acknowledge abuse can cause them to stop seeking help. Healthcare providers can ask about abuse by avoiding the terms “violence” or “abuse” and focusing on the feelings and behaviors that patients have experienced. Verbal descriptions, using terms such as hitting, slapping, pushing, yelling, threatening, or “putting you down,” while asking questions may enable patients to gain understanding that they are involved in an abusive relationship. Arguing with patients’ perceptions or to trying to get them to verbally disclose or acknowledge abuse will not help. However, expressing concern for patients’ safety can be helpful, especially when healthcare providers have assessed that patients are denying or minimizing the immediate risk of danger to themselves (Fleck-Henderson, 2004; Nicolaidis et al., 2003).

Ms. D

Although little published research data exist, evidence described in the literature suggests that gay male couples and lesbian couples have similar prevalence rates and similar patterns of abuse as heterosexual couples (Fleck-Henderson, 2004; National Center for Injury Prevention and Control, 2005; PsychPage.com, 2004). Healthcare providers may become frustrated trying to understand why patients would choose to stay in abusive relationships, so gaining understanding that leaving an abusive relationship can be very dangerous is important. For example, when Ms. D, a 43-year-old female survivor of breast cancer, arrived at the clinic for her annual check-up, she introduced Ms. O as her partner. Prior to assessing Ms. D, the nurse reviewed her medical record and nursing care plan and noted documentation of Ms. D’s requests for information about IPV on several previous clinic visits. Several nurses’ notes indicated Ms. D attributed many of her symptoms to “relationship stress” and “repeated break-ups.” The patient teaching plan included documentation of written and verbal information about IPV that had been provided. The documentation provided important insight for continued assessment and interventions for support of Ms. D’s management of her situation.

Battering usually follows a distinct pattern of tension building, an eruption of violence, and then a calmer (honeymoon) period, referred to as the cycle of violence (Family Violence Law Center, 2005). The cycle of violence often is kept in motion by love, memories of more good times than bad times, focus on knowing “the good characteristics” of a partner, and an individual’s hopes and fears. Fears can result from threats of violence by the abuser, such as threats to kill themselves, the victim, or their friends or family or to abduct children. Victims of abuse constantly are making wise decisions so they can survive. A decision to leave a relationship is one option, but it is not the only option they will have to consider. Supporting victims to remain in the relationship until they are able to leave safely is always wiser. Data support that leaving an abusive relationship is a process that may take months or years of planning and often involves a pattern of leaving and returning to a relationship five to seven times before permanently leaving. Sometimes the initial purpose of leaving is to test whether an abuser will seek help or will stop the violence or to gather resource information to develop a plan to leave the relationship permanently. Once victims have developed a plan for safety, including plans for a job, childcare, and housing, they may finally leave for the last time. Most victims of IPV do leave the abusive relationship eventually (Fleck-Henderson, 2004).

Battering behavior often is used to make victims feel responsible for the violence they experience; therefore, most victims will be sensitive to any statements that confirm or add to their feelings of self-blame. Questions that begin with “why” can sound accusatory and judgmental (Fleck-Henderson, 2004). Healthcare providers always should affirm that the batterer is the one who is responsible for the violence. Whenever patients make a decision to return home with an abuser, healthcare providers should support the decision and offer reassurance that resources are available if they are needed in the future (National Guideline Clearinghouse, 2005).

Offering information about local DV resources and legal rights should include the need for patients to develop a detailed plan in case violence reoccurs, including identifying safe places and resources. Assistance to identify items, such as a driver’s license or other identification, birth certificates for self and children, social security cards, keys, checkbook, bank card, health information cards, certificates or other legal documents that will be needed if patients decide to leave the relationship permanently is helpful. Healthcare providers can ask questions that will guide patients to identify useful coping strategies and resources (National Guideline Clearinghouse, 2005).

Asking specific questions about activities, places, or people that have functioned as support resources for patients can assist them with developing or maintaining a safety plan. Healthcare providers should ask about what patients have done in the past to remain safe and also determine the effectiveness of the safety plan that was used by discussing the outcomes experienced when the plan was implemented. Initiating the discussion provides an opportunity to review and add to the plan that individuals already are using to manage and survive in their relationship or domestic situation. Taking the time to review the safety plan will support patients’ ability to be in control of decision making and also allows healthcare providers an opportunity to offer empathy and support (Fleck-Henderson, 2004).

Nursing Assessment: Screening for Intimate Partner Violence

DV can affect any gender, culture, age group, or social class (National Guideline Clearinghouse, 2005). The best way to identify DV is to ask all patients in all clinical settings about abuse. Developing questions to inquire about abuse as a standard part of a patient assessment will make it less threatening for some patients to respond. Most victims will not spontaneously volunteer information about abuse, but some will openly discuss it when they are directly asked. It is always better for healthcare providers to ask a question about abuse and be told that none exists than to miss an opportunity to provide support and information about IPV to patients who need intervention (Fleck-Henderson, 2004).

An assessment for abuse should be conducted in private with no friends, relatives, or caregivers present. Exceptions include agreeing to the presence of children younger than three years
of age because they are less likely to understand any of the verbal communications about violence, having a language interpreter who is not a patient’s friend or family member, or using a language line service. Raising the question about abuse and acknowledging patients’ situations are important interventions (National Guideline Clearinghouse, 2005; Office on Child Abuse and Neglect, Caliber Associates, 2003). Healthcare providers must establish a supportive environment during assessments. Offering nonjudgmental support will provide the opportunity for patients to discuss abuse, allowing healthcare providers to gather information about associated health problems to determine a plan of care for immediate and long-term health and safety needs and to provide needed resources, information, and treatment (Fleck-Henderson, 2004). Regular assessment by skilled healthcare providers can increase the identification of victims of IPV, as well as those who are at risk for abuse.

Identification of IPV allows healthcare providers to offer a choice of available resources, such as social workers, local DV resources, or the National DV Hotline (800-799-SAFE, 800-787-3224 [telecommunications device for the deaf]) (Family Violence Prevention Fund, 2004). Making victims aware that healthcare providers are available to provide assistance can be accomplished by maintaining culturally diverse patient education materials in examination rooms, staff lounges, and restrooms with information acknowledging that the healthcare setting is a safe place to discuss abuse and ask for assistance (National Guideline Clearinghouse, 2005).

When healthcare providers identify patients facing abuse, they have the opportunity to address one of the many psychosocial concerns that can be faced by patients who have been diagnosed with cancer. Healthcare providers can have a positive impact on IPV in all patient populations by seeking education about DV and by routinely assessing for signs and symptoms of abuse to meet standards of care for providing informational and emotional support in response to every patient’s identified concerns.

Oncology nursing practice is based on a holistic approach to patient care, which supports that identification of physical and psychosocial needs are equally important. Oncology nursing provides many unique opportunities to help patients cope with cancer. Routine nursing assessment for signs and/or symptoms of abuse will provide an opportunity to help patients manage not only the life-threatening aspects of a diagnosis of cancer but also the life-threatening aspects of IPV. Therefore, assessment for IPV to identify signs and symptoms of abuse is an important, significant component of holistic care in oncology nursing practice.

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