The CARE approach:

Supporting women who disclose intimate partner violence

Disclosing abuse for the first time transfers power back to the patient as she begins to move toward safety. Nurses can consider, acknowledge, respond, and empower while building a trusting relationship during routine screening.

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Health screenings are part of routine care for patients. Routine screenings may include hypertension; breast, cervical, or colon cancer; or diabetes. Patients may also be screened for mental health disorders. Unfortunately, screening for intimate partner violence (IPV) isn't necessarily routine.

One in three women in the US experiences some form of contact sexual violence, physical violence, or stalking during her lifetime. Forty-seven percent of women also experience psychological aggression. The CDC has reported that more than half (55.3%) of all female murders are IPV related. The high prevalence rate of IPV suggests that screening should be conducted during clinical visits.

Many government agencies and professional organizations recommend routine screening for IPV. The US Preventive Services Task Force suggests that IPV screening be conducted for all women ages 14 to 46, and healthcare providers should offer referrals for women experiencing abuse to community agencies that assist this population. In August 2012, the Affordable Care Act was amended to include abuse screening coverage for all women and adolescent girls. The American Academy of Family Physicians recommends routinely discussing IPV and family violence with patients in a nonjudgmental manner. The Committee on Health Care for Underserved Women of the American College of Obstetricians and Gynecologists recommends that screening during obstetric care take place at the initial visit and at least once per trimester.

Nurses are well positioned to provide IPV screening because they may be the first healthcare professional that the patient encounters. However, barriers to routine use of IPV screening tools

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still exist, including lack of knowledge and training and limited time. Boosting nurses' knowledge and confidence in conducting IPV screening may raise screening rates, which, in turn, may increase disclosures.

Difficult disclosure

There are several IPV screening tools that can be used in the clinical setting. The Abuse Assessment Screen is a five-item questionnaire administered by a clinician, including a question about pregnancy and a body map to document injury locations. The Computer Based IPV Questionnaire is a 14-item computerized self-report for men and women that assesses physical and emotional IPV, suicidal ideation, sexual violence, and access to handguns. Administered by a clinician or self-reported, the HITS (Hurt, Insult, Threaten, and Scream) Domestic Violence Screening Tool for men and women includes four items to assess the frequency of IPV. Administered by a clinician, the Partner Violence Screen uses three items to assess physical IPV and current safety. And the Women Abuse Screening Tool is a 7-item self-report assessing physical and emotional IPV.

It must be acknowledged that many women don't disclose IPV and obtaining a disclosure may be challenging. There are many reasons why women don't leave an abusive relationship. The biggest reason is the fear of retaliation. The woman has seen what her abuser is capable of doing and fears follow-through on threats of harm if she leaves. Other reasons include lack of financial resources, fear of losing her children, a belief that the abuser will change, guilt, feelings of embarrassment, fear that no one will believe her, or lack of support from family or friends. Women don't just leave an

did you know?

A major component of caring for victims of IPV is the nurse-patient relationship. Disclosure of IPV is an extremely personal and emotional act. When utilizing the CARE model, consider Swanson's Theory of Caring. This nursing theory, centered on "informed caring for the well-being of others," fosters delivery of essential care while respecting patients, sustaining their self-worth, and empowering them.

abusive relationship, they *escape* an abusive relationship.

Three different types of disclosure have been identified. A disclosure may be spontaneous as the woman comes forward and presents her situation during a clinical visit without being prompted. It may be received from a police report or emergency medical services worker. Or it may be initiated by the nurse inquiring about IPV using a validated screening tool required for all clinical visits when conducting routine screenings. There may be times when the nurse suspects IPV based on assessment of physical exam findings or observation of behaviors during the clinical visit, but the woman denies any abuse when questioned.

A trusting relationship is critical for a woman to come forward and disclose abuse. Establishing a trusting relationship must begin by ensuring a safe, private environment to talk about sensitive topics and offering a caring approach while feeling confident to respond when IPV is suspected or a disclosure is made. To build confidence in responding to IPV disclosures, utilizing a model of care can be beneficial.

The CARE model

- **C** CONSIDER and respect feelings and responses to IPV screening.
- **A** ACKNOWLEDGE and discuss the victim's feelings.
- **R** RESPOND by reviewing options and assisting with needs.
- **E** EMPOWER by offering referrals and resources.

The CARE model

The CARE (Consider, Acknowledge, Respond, Empower) model is one method that may be used to offer the caring behaviors essential for supporting a woman when she discloses IPV (see *The CARE model*). Let's take a closer look.

Consider

Consider and respect the patient's feelings and responses to IPV screening. Victims of IPV aren't always willing to accept assistance. Remain nonjudgmental and be empathetic while establishing trust. Nursing strategies include sitting at eye level, utilizing eye contact, and listening first. Creating a comfortable and safe environment includes open body language. Remember that each patient's situation is different. For example, victims may deny obvious abuse, be unwilling to talk about the abuse, or feel uncomfortable discussing it. Within this stage, you'll begin to understand the patient's situation and then you can acknowledge her feelings.

Acknowledge

Accept the patient's feelings, acknowledge that her situation is real, believe what she's saying is true, and discuss the situation. Victims of IPV are often scared or embarrassed and may be initially reluctant to discuss details. Recognize and acknowledge the courage it takes to speak about abuse and be empathetic while executing an action plan for willing patients. Bringing up the issue, creating a trusting bond, and acknowledging the situation are crucial to the CARE approach. During the discussion, the patient may initially repudiate involvement in a hostile relationship; financial restrictions or safety issues may cause her not to leave the relationship. If abuse is presumed but refuted by the patient, you must accept her responses to questions. Remain supportive and know that these discussions begin to introduce options and resources to the patient.

consider this

Male victims of IPV

Despite a large percentage of female-identified IPV survivors, nurses must not forget that victims of IPV also include male-identified survivors. The National Intimate Partner and Sexual Violence Survey revealed that the lifetime experience of IPV for gay men is 26%; bisexual men, 37.3%; and heterosexual men, 29%. However, IPV incidence for men is often underestimated. Nurses must recognize the unique barriers that men face when accessing services. Male-identified IPV victims often have a diminished sense of self-worth because of society's expectations that they can protect themselves. Men may feel ashamed and elect not to reveal the incident due to family or cultural beliefs. In addition, they may minimize the extent of the violence. Also, men often experience physical violence that may not leave obvious injuries, such as being slapped, pushed, or shoved. It's essential when conducting screening or providing care for IPV victims to recognize and understand causes across the gender spectrum.

Respond

Respond to the patient by discussing her concerns, reviewing available options, and assisting with needs. After understanding the patient's needs, you can move toward reviewing information and resources. The patient may not be ready for or feel comfortable talking about her situation, but it's in the response phase that she'll be aware of the options and may begin to seek help. If the patient feels that she can no longer stay in the relationship, identify community support systems and have the contact information ready to give her when she can safely keep it. Safe shelters, protective orders, and reporting to law enforcement are a few options to consider, although the patient must decide what's best for her at the time. Emphasize that when the patient is ready, she can reach out to the support agency she feels meets her needs.

Empower

Provide the patient with the assistance she needs to move toward a state of well-being by offering referrals and resources. Encourage the patient's inner strength by stressing that there's power in disclosing; saying things out loud takes the power away from her abuser. Offer information and resources to all patients despite screening results. Some victims of IPV may not divulge the abuse but may choose to accept information to utilize when they're ready.

Even if the patient denies IPV, the CARE approach can open the door when she's ready to seek assistance.

Putting CARE into practice

Nurses are skilled at providing nonjudgmental care and building a trusting relationship with patients. When care requires addressing a sensitive topic, beginning a discussion can be difficult. To help ease into the discussion of IPV, using an opening statement can be a

on the web

Futures Without Violence:
www.futureswithoutviolence.org
415-678-5500 (TTY: 866-678-8901)

Love Is Respect:
www.loveisrespect.org
1-866-331-9474 (TTY: 1-866-331-8453)
Text loveis to 22522

National Domestic Violence Hotline:
www.thehotline.org
1-800-799-SAFE (7233)

National Sexual Assault Hotline:
www.rainn.org
1-800-656 HOPE (4673)

positive introduction. For example, consider beginning with, "We also screen for intimate partner violence because just like high blood pressure, it can affect a person's health and well-being." Other examples for initiating this difficult conversation include: "We hear so much about intimate partner violence affecting so many women, I routinely ask everyone" or "I've asked you a lot of questions about your health background, I would also like to ask about your relationship." You may substitute the term *intimate partner violence* with *domestic violence* or *abuse* because these are also commonly used and may be more familiar to your patients.

Consider the following scenario. You enter the room and notice your female patient has a bruise on her forearm. She's responding to a text message and appears to be upset. She states that her husband wants her to come home immediately and says she shouldn't have come by herself, but she thought it would be okay because she thought she only had a sinus infection. Her phone is now ringing and she says she must answer it or she'll be in trouble. She appears visibly upset after the phone call, then says she needs to leave. Do you see any red flags? How would you initiate a conversation about IPV? How would applying the CARE model support your response in this scenario?

The urgency to respond to her husband and leave without treatment and the bruise on her arm are red flags. Begin with an opening statement to convey that your questions are routine and you're concerned about the patient's health and safety, then tell her that all information shared will be kept confidential. Application of the CARE model may include:

- Consider the patient's feelings about wanting to leave quickly and ask if she feels safe to go home.
- Acknowledge that she's in a hurry and reassure her that you're there to assist her at any time.
- Respond by offering her resources to use when she's ready to seek help.
- Empower her by opening the door for communication; she now knows that she can return for assistance and access to resources even with the brief time you've spent with her.

Opening the door

Nurses may find it difficult to discuss IPV and be unsure of how to care for women who disclose it. Incorporating the CARE model gives you a process to consistently care for these patients. Even if the patient denies IPV, the CARE approach can open the door when she's ready to seek assistance. ■

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