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[Images of nurses with patients in hallway. Stops at a sign that reads Nurse's Station. Photo of two women speaking.]
[Text on screen] CNE201-0018 Domestic Violence Pt. 1
[Nurse Chez] An act of domestic violence occurs every 15 seconds. More frequently then any other crime in the United States.
Although estimates vary, it is believed that over six million men, women and children are victims of some form of violence. Two to four million of those victims are women. It is difficult to estimate exactly how many children may be witnesses to marital violence. But it is estimated that one million to 30 million children have witnessed some form of family violence as well as may also be victims of family violence themselves in terms of sexual, physical abuse directly and neglect.
Although men can be victims of violence, domestic violence, the majority of victims are women. Therefore, this program will focus on the female abused partner or spouse and the children who are victims of that violence as well.
[Text on screen]Domestic Violence Pt. 1 Learning Objectives: 1. Domestic Violence/Family Violence 2. Forms of Abuse 3. Identifying the Batterer 4. Identifying Signs and Symptoms
[Nurse Chez] This program will be divided into two parts. Part one will focus on the nature of domestic violence/family violence, the nature of the abuse and the relationship, the batterer. And signs and symptoms to watch out for and be aware of so that you can identify the victim.
[Text on screen] Nancy Chez, RN, MA, CCRN, CEN, Clinical Instructor, N.Y. Hospital
[Nurse Chez] The content has been compiled from the firsthand experiences and writings from experts across the country. Special acknowledgment goes to the New York State Coalition for Domestic Violence and the New Jersey Coalition on Battered Women.
[Woman and Nurse Chez talking in hospital]
[Nurse Chez] Hopefully our ability to recognize and then intervene will help victims break the abusive cycle.
[Nurse Chez] In this context, family violence and domestic violence can be used interchangeably. You'll hear me refer to both of those terms.
[Definition of family violence]
[Nurse Chez] Most definitions include or refer to family violence as the cycle or pattern of sexual, physical and psychological abuse usually between intimate partners.
So the key words here are intimacy and pattern. The cycle.
[Chart listing types of relationships]
Most definitions include the -- of intimate relationships will include the following intimate relationships: legally married spouses, divorced and separated partners, dating partners or non-married couples, same-gender partners, children, the elderly, abuse between siblings, and parent abuse by children.
[List of the types of abuse]

[Nurse Chez] It's a term that captures a large group of or types of assaults and problems, such as sexual assaults, child abuse, sibling abuse, parent abuse, elder abuse and rape, as a form of sexual assault.
And it can be distinguished from anonymous assaults such as a mugging or a street crime by the very nature of the behavior.
[Scene of wife sitting and husband standing over her speaking to nurse.]
[Nurse Chez] Usually we see intimacy -- again, we see intimacy in pattern, which is something we don't usually see in an anonymous assault. There are a lot of myths which pervade our society.
I'd like to go through some of them and if you'd like to, you can follow in your study guide. They're listed there. As you go through, try to answer based on your gut reaction and not what you would want -- what you would think the answer should be.
[Myths and Realities Slide No. 1]
The first myth is family violence is most often committed by persons who suffer from mental illness. Remember that whether the answer that I say is true or false is not as important as the explanation.
[Scene of man and woman fighting. Man grabs woman by shirt and pushes her into wall yelling at her.]
[Nurse Chez] The answer to this first myth is that it's actually false. Abuse is felt to be a learned behavior. It is not subject to mental illness or individual pathology. A person is violent and abusive because they've learned to be that way. They've learned that it's effective and it works. And it can manage the relationship.
If there is an upside to this statement, then that is that, if it's a learned behavior, hopefully it can be unlearned through counseling and therapy. And many batterers are helped through counseling and therapy.
[Myths and Realities Slide No. 2]
The second myth is that family violence occurs most often among the lower class. This is also false. But it's a commonly held belief and there's a stereotype that it would occur among the lower class or minorities.
[Scene of husband and wife with nurse having discussion]
[Nurse Chez] Actually research has shown us that it will occur throughout all age groups, all races, religions, socioeconomic groups and cultures.
[Abuse occurs in all ethnic, religious, age & social groups displays over a scene where a nurse counsels a distressed couple¬]
Why don't we hear about it most often among the middle and upper classes? Well, it's felt that perhaps they have access more readily to private help such as legal assistance or counseling or shelter and are not as -- not in need of public assistance.
In addition, unfortunately, because of the stereotype, even healthcare providers tend not to look for domestic violence or signs of it in the upper and middle classes. And therefore we fail as healthcare professionals to identify victims -- many of the victims.
[Myths and Realities Slide No. 3]
Children who are abused or witness abuse will grow up to be abusive. And that is actually true for the most part.
[Scene of boy playing.]

[Nurse Chez] Research supports a strong correlation between boys who have witnessed abuse when they were younger or even received abuse and violence to grow up and be abusive themselves.
[Text saying children learn to be abusive]
[Nurse Chez] There's a strong correlation between the two. Research does not support the same kind of risk for women.
[Myths and Realities Slide No. 4]
The fourth is -- the fourth myth is that up to 500 women are beaten to death annually. And unfortunately this is a low estimate. According to the FBI up to 4,000 women are beaten to death annually.
[Scene of a bruised woman crying]
[Myths and Realities Slide No. 5]
[Nurse Chez] Number five. Violence rarely occurs between dating partners. Unfortunately this is false as well, but the studies vary.
[Scene of a man and woman yelling at each other. The man hits the woman]
[Nurse Chez] The studies will tell you that anywhere from 22 to 67 percent of dating partners experience violence.
[Myths and Realities Slide No. 6]
[Nurse Chez] Number six. Violence only occurs between heterosexual partners. That is unfortunately false as well.
[Scene with two women yelling and fighting. Woman 1 repeatedly slaps woman 2. They fight and woman 2 flees room.]
[Nurse Chez] There are more and more -- there's more and more research to support that same gender partners experience violence and abuse within their relationships for varied but similar reasons.
[Myths and Realities Slide No. 7]
[Nurse Chez] Number seven. Alcohol is a major cause of violence in the home. A lot of people would think that this is a true statement.
[Scene of a man with a drink confronting woman. Argument and man pushes woman to couch then begins to hit her then leaves room]
[Nurse Chez] I'd ask you to think for a moment whether you think that violence is a cause -- whether alcohol is a cause of violent behavior or is it just often associated with violent behavior?
[Text saying alcohol does not cause violence]
[Nurse Chez] What we find is that many batterers also use alcohol. But we have to be careful when we use an excuse such as alcoholism for violent behavior because as I said before, it's really a learned behavior.
If you take an alcoholic batterer and you treat them for the alcoholism, you will still have a batterer. They will be sober, but they will still batter and be violent because alcoholism is a separate problem than battering. The two need to be treated separately.
[Myths and Realities Slide No. 8]
[Nurse Chez] Number eight. Abused women can end the violence by divorcing their partners. Unfortunately this is false as well. The United States Department of Justice has found that three quarters of all spousal attacks occur following a separation or divorce.
In fact, violence may often occur -- or after the separation process when it never had occurred before. The separation process very often precipitates the violent acts. In fact we may want to remember this when we're wondering why women don't leave a situation which is violent. And

very often they don't because they're afraid or have been threatened that they will be hurt or killed if they do leave.
[Myths and Realities Slide No. 9]
[Nurse Chez] Stress makes the abuser commit acts of violence. Again, we need to be careful when we use an excuse for the violent behavior. Stress is often used as an excuse. But most importantly, violence is a learned behavior.
[Scene of man pulling woman from chair, yelling at her and hitting her head into wall]
[Nurse Chez] The batterers learn that they can respond violently to such feelings as stress, frustration and anger.
[Text saying violence is not caused by stress]
[Nurse Chez] And that it works. It's effective in controlling the relationship. If you think about how many of us have stress in our lives, it is only those of us who are violent and learn to be violent, will respond violently to stress.
[Myths and Realities Slide No. 10]
[Nurse Chez] Battering frequently begins or escalates during pregnancy. This is a true statement. And research has supported that very often violence will be precipitated by the woman becoming pregnant.
[Text saying battering may start or intensify during pregnancy]
[Nurse Chez] It may also escalate during pregnancy.
[Scenes of pregnant women walking.]
[Nurse Chez] Why do you think this is true?
Research has -- there are a lot of theories which have focused on why this happens. Some of the theories will say that the batterer, who is most often having -- has a low self esteem and is very often extremely possessive of the woman and sees the woman as part of his property, will be jealous of the intrusion of the fetus.
Also, if we think about the pregnant woman, very often pregnant women get a lot of attention from their healthcare provider, family, and friends, and so there is a good deal of jealousy for that reason.
Interestingly enough, the battering which occurs for pregnant women is very often in a central location, very often directed towards the abdomen.
[Myths and Realities Slide No. 11]
[Nurse Chez] Number 11. The victim can learn not to provoke violence in abusive relationship. This is not true at all. We know that the batterer needs no provocation.
[Scene of man hitting woman in chair.]
[Nurse Chez] The response of the battering behavior or violent behavior is solely the batterers.
[Text saying victims cannot control provocateurs]
[Nurse Chez] We try not to ever really think of it as being the victim's problem or responsibility. That's a very important point to realize.
Often victims may, although they want to try to control the behavior, they will be unable to. There's nothing in a victim's behavior that provokes or can control a violent act from the batterer's perspective.
[Myths and Realities Chart No. 12]
Victims may blame themselves for the abuse. This is true.
[Scene of woman and nurse talking in hospital setting.]

[Nurse Chez] Many victims are embarrassed and ashamed and feel a sense of responsibility for the batterer's behavior.
[Text saying victims feel responsible]
[Nurse Chez] In addition, and unfortunately, friends and family although well meaning, and including healthcare providers, may tend to blame the victim, feeling that perhaps there was something that they could -- the victim could do to stop the violent act. And this is usually because everybody is very concerned about the victim. It's not a malicious intent. But people tend to try to find a way to stop it and usually ask the victim to try and do that.
[Myths and Realities Slide No. 13]
[Nurse Chez] The last myth is that abused women typically delay reporting, conceal the source of their problem and are reluctant to seek help. And I suppose that a lot of us would think that was true. Unfortunately, many women do attempt to disclose their battered behavior.
[Scene of husband getting nurse to assist wife. Husband explaining problems of wife. Wife looking away and not speaking]
[Nurse Chez] And that's not unfortunate, but what's unfortunate is that a lot of us don't actually realize that that's what they're doing. They are met with such disbelief, disinterest and even patronizing attitudes from many healthcare providers, so that they are embarrassed and ashamed by the time they actually do attempt to disclose the truth.
In fact, many victims do disclose the battered behavior. It's simply not recognized as a disclosure. A frightening statistic is that one out of every four to one out of every ten women that we see as nurses in our healthcare practice are victims of some form of violence.
We have just reviewed some common myths. What do you think that myths -- what effect do you think that myths have on the caregiver's judgment? If you think about it, if we believe in something that's not true, we are basically saying that we're unaware of the problem.
If we are unaware of something, we don't talk about it. So it's left unspoken, ultimately unrecognized then. And the worst consequence is that we don't treat it. It is left untreated. And that is what has happened for a very long time with this particular problem.
[Scene of nurse and woman talking in hospital]
[Nurse Chez] Why is domestic violence, if it is so wide spread, why is it not recognized? That's an important question to think about. Because as healthcare professionals, we see this sort of -- these victims every single day of our careers.
[Scene of police arresting man. Woman arguing with police. Police subduing woman to calm her down]
[Nurse Chez] Did you know that women -- violence against women is more frequent then any other crime against women, including muggings, auto accidents and rape combined? And yet fewer then one in 25 are recognized as such by the healthcare team.
If it is so common then, why does society not recognize battering or violence against adults as often as we choose to see at this moment, particular time, child abuse? Society no longer disputes that it is an obligation and in fact a law in most states to protect the child and to intervene in the case of child abuse. But what about the adults?
Up until now, what has domestic violence or family violence -- whose problem has it been? Well, very often family violence has been the problem of the family. It is felt that it was a private matter. Not really appropriate for outside intervention and really not as serious of a crime, which is part of the reason why nobody has really wanted to intervene.

It is very scary, in addition, to imagine that any of us could be so vulnerable as to be involved in something that's so widespread, which spans across so many sociocultural groups, to imagine that any of us would be in a situation where we would -- could possibly be in danger of our lives.
[Scene of nurse and woman talking in hospital]
[Nurse Chez] Often well meaning family friends and again, the healthcare professional, try to understand what they would do, given the same situation. And out of those thoughts come questions or statements towards the victim such as. "You know, if I were you I would just leave." "I don't understand why you stay in that situation." "If it was me, I would never let it happen." Or, "What did you do to provoke him?"
And these again aren't meant to be malicious, but to try to understand what's happened. The problem is, what effect do they have on the victim? It's as if the person asking the question was saying, you know, I'm pretty healthy and I would leave the situation. Therefore, there must be something wrong with you.
If you were a victim, how would you feel? Well, what this tends to do is to undermine the victim's confidence, to somehow imply that they are weak or inferior and that they've done nothing to try and avoid the situation.
In other words, we blame the victim for the batterer's behavior. That decreases their attempts to ask for help. In essence, what we end up doing is increasing their isolation. Often victims will be silent. They decrease their efforts for help and ultimately their efforts to escape. And many of them are prisoners of their own home for this very reason.
So far we've looked at the victim and what society does with the victim in terms of their views and their response. But what about the batterers?
[Scene of husband and wife in hospital. Husband shows affection to his wife]
[Nurse Chez] Why do we have people who are violent and battering?
It's important to understand some of the commonly found characteristics. Some of you may have worked with batterers or abusers in your healthcare areas. Try to think about their behavior towards you and towards the victim. Often there are some common characteristics.
There's no special appearance of a victim or a batterer. And yet we see these people every day. Some commonly found characteristics: remember that many of them were abused as children so that they may be more likely, then, to come in and feel some remorse for what they've done. Very often these children feel embarrassed and ashamed for what's happened to them.
[Nurse consults with husband and wife. Husband talks while the wife remains silent]
[Nurse Chez] During the battering episode though, they're not always aware that that's what's going on. If you see them in a healthcare setting, you're usually seeing them during a specific phase of the battering cycle, which is following a violent episode. They're more likely to show a great deal of remorse towards the victim, be very caring, very concerned.
The husband was very concerned about his wife, wanting her to have care immediately. Very angry with the healthcare professionals for delaying her care and her intervention. Those are cues. Not that everybody who comes in who is caring about their partner would be a batterer, but you have to put the whole picture together.
They're often, again, over-solicitous. They'll attempt to answer questions. The husband would not allow his wife to speak. Why do they do that?
Well, if you think about the story, it's in an effort to hide what the truth is. They often will make up a story and you'll need to look at certain characteristics of the story. And we're going to talk about that.
[Chart listing clues]

[Nurse Chez] So again, we're talking about someone who is over-solicitous, who attempts to answer questions for the victim, who does not allow the victim to express what's going on, to actually disclose any of the information. Often the seriousness of the violence is blamed on the victim's provocations and it is also very often minimized.
Many of these batterers are jealous or have a very low self esteem, a very poor view of themselves. And so it is an attempt to make themselves feel better that they strike out.
There are also commonly viewed traditional views of sex, parenting, and negative attitudes towards women. In fact up until this first -- up until this century, the views of women were very different then they are now. The views have only begun to change. Up until this century the woman was thought of as having to be part of the husband's property in some way.
[Scene of man pushing and hitting woman]
[Nurse Chez] There are multiple theories which describe how a battering episode would occur. Remember that in the beginning I said that it was a pattern. Generally there is a pattern to follow.
[Chart of the battering cycle]
[Nurse Chez] One of the theories describes the episodes as having periods of escalation and de-escalation. You don't necessarily have to use these terms but it's important to understand that there is usually a period of quiet where there is some tension building.
Alcoholic batterers will start drinking during this phase. Sometimes the victims cue into this period or are aware of this period of tension. And at any moment there may be a trigger which would then produce a violent act. That is the third phase, which is a violent act.
Again, not important to remember the phases, but to know that during the violent escalation and violent act period, frequently victims are unable to leave the situation for fear that they will be harmed more severely then is happening during that violent act period. You may not see victims in other words at the hospital setting because they're literally trapped at home in some cases.
[Chart of Battering Cycle, again]
[Nurse Chez] Following the violent act there is an opportunity for the husband or the partner, whoever was the batterer, to show remorse for what has happened. There are apologies, gifts, periods of time where the batterer is the nicest they could possibly be. Promising never to do it, making excuses for the behavior, such as the alcohol caused it or it was a bad day at work.
And, unfortunately, this is a period of time which is very effective in keeping the victim in the relationship. Having them hope that eventually the battering will stop and this is in fact hopefully the last time.
Over time in the evolution of this kind of battering cycle, the gifts and apologies will diminish.
[Scene of man and woman arguing. Man grabs woman throws on chair and hits her]
[Nurse Chez] And there are just periods of tension and then violent acts followed by tension and violent act. This has been described or compared to a war zone.
Literally, the victim is trapped in a relationship and unable to seek medical attention. They really have nowhere to go. This is also the period of time when the victim will try to manage the relationship to try and avoid any kind of altercation for fear of losing the children or for fear of harm to themselves and their children.
Given that adults involve themselves in relationships mostly on the basis of choice, it may be difficult particularly for healthcare professionals to understand why they often are unable to leave a situation. Some of those reasons are listed in your study guide.
[Chart explaining why victims stay]

[Nurse Chez] Just to name a few, very often victims are -- have no known place to go, there are no resources for them or they are unaware of the resources, there's lack of education, lack of housing, emotional ties to the abuser, fear that there will be no child custody. Those are just some of the reasons why victims stay.
Let's look at some of the signs and symptoms that you may need to look for in order to identify the victims of abuse. There are specific forms of abuse to begin with. At the heart of every abusive relationship, and this is important to remember, are power and control.
[Chart explaining components of power and control]
[Nurse Chez] The abuser uses power to manage the relationship and control aspects of the victim's personality. So that will be at the heart, no matter what type or form of abuse exists. The forms are physical, sexual abuse, emotional/psychological abuse, economic abuse and threats. Those are also listed in your study guide in more detail.
Some of the signs and symptoms that you'll need to look for -- and remember when I talk about signs and symptoms you're not looking for them in a single sign or symptom. They're actually clues that more investigation needs to be made concerning the abuser, the victim's situation. In general, you can divide these into physical and behavioral indicators.
[Chart of Signs and Symptoms]
[Nurse Chez] Physical indicators. When you're looking at physical indicators, be sure to look for two very specific items. One is, does the story that you are hearing match the pattern of injury? Number one. Number two, is the pattern of injury plausible for the developmental stage of the victim?
For example, you see a two month old that comes in and the story is that the two month old rolled over onto a hot curling iron. It's very difficult for two months old -- two month old children to roll over. So that is unlikely for the developmental stage. Or a 20 year old comes in with a lacerated lip, several bruises on the face and abdominal pain, but tells you that she fell on the sidewalk. Highly unlikely based on the story.
Remember that when victims give you a story such as I fell, generally when you fall you are more apt to injure your extremities. Signs and symptoms of abuse are generally central, in the face, the neck, the chest and the abdomen and the genitalia.
[Photo of man holding woman against wall]
[Nurse Chez] You're also looking for bruises possibly in various stages of healing.
Photo of burned child]
[Nurse Chez] Burns which take on a particular form such as a cigarette burn or in the shape of an article such as an iron or a curling iron or a rope. Or a slap mark on the face. Any kind of pattern injury.
You'll also want to look at fractures. Particular fractures of the face, the head, the hard and large bones of the body as well as spiral fractures. Spiral fracture, it's difficult to obtain that kind of fracture without someone actually taking the limb and twisting the limb.
You may also see old injuries. Victims who come to you with a story that they were unable to get to the hospital any sooner then now and the injury is you know, something like a few weeks or a month old are suspicious injuries.
Evidence of sexual assault. Torn, stained, bloody underwear, difficulty walking and sitting. Certainly verbalization that they have been attacked or abused is worthwhile going through immediate intervention without any signs and symptoms.
[Scene of moving her coat and tissues around with her head bowed]

[Nurse Chez] Some behavioral characteristics, be sure to look at the victim's behavior. That may be the only sign or symptom you see. It is important to look for the subtle clues such as a statement of saying that I was just accident prone or clumsy. That is a very common complaint. Unfortunately we see a lot of victims come into the hospital with minor complaints such as headache, abdominal pain, malaise, dyspareunia or pain on intercourse, and depression. These are not minor in and of themselves, but very often is hard for healthcare providers to understand why a victim would come into say, an emergency setting with that type of complaint.
Be very careful, sometimes these victims have sustained abuse for up to years. And this is the only sign and symptom that you are seeing. Often they are worked up for their chief complaint of headache and then sent home to the real and most dangerous problem, which was abuse and untreated for that problem.
[Scene of man pulling woman from chair and yelling at her]
[Nurse Chez] Those are some of the signs and symptoms. Many of them are listed in your study guide. Those are the important signs and symptoms to be looking for when you are looking for abuse. Hopefully you will be able to recognize at least one sign, which would then cue you to want to ask further questions and to investigate with the victim if there's a possibility that there is a problem at home.
[Music playing]
[Special Thanks To: The New York Hospital - Cornell Medical Center, New York, New York. Patty Sweeney, RN. Theodore Angelus.]
[The content of this program provides at least one perspective for the health care situation(s) depicted. Previous training and experience, hospital policy, as well as local, State and Federal laws, should be taken into consideration prior to any modification of treatment or therapy. Consult your hospital's policies and procedures.]

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[animated introductory sequence]
[Text on screen] CNE 201-0019 Domestic Violence Pt. 2
[Nurse Chez] In part two we will now review intervention strategies. Specifically those for the adult and the child.
[Scene of a battered woman.]
[Nurse Chez] The professional intervention outlined is appropriate and necessary for all types of victims. We will focus mostly on the female adult patient, but know that they -- that domestic violence affects all types of victims. And therefore these intervention strategies can be broadened and used for all types of victims.
[Slide - Intervention for the Victim - What is first priority?]
[Nurse Chez] What would you think would be the first priority when you are encountered by a victim? What would be your first gut reaction?
[scene of nurse speaking with a female patient and her husband]

As a nurse we tend to want to protect our patients, to save them from any danger that's going to come their way.
So your first intervention, your first gut reaction of safety is appropriate. That is understandable that that would be what you want to do. And you would need to determine whether the patient is safe from a physical or an emotional standpoint.
But who do you think is the best person to judge, to make that decision? Actually it's the patient, the victim of domestic violence. The victim of the violence at home is the best judge of whether it is safe for her to return to that environment. And that is difficult sometimes to relinquish that kind of control on our part as professionals. But it is very important.
[slide on why victims need to make the judgment to leave]
Why is it so important? Well first of all the victims know exactly what the risk is for them should they decide to leave. So they are the best judge to decide when to leave first of all.
[Nancy Chez, RN, MA, CCRN, CEN Clinical Instructor, NY Hospital] Second of all, the person who is the best judge to leave, being that it's the woman, has survived this abuse for so long. Surviving abuse means that they have had total control taken away from them in every way.
[slide on why the victim needs to make the judgment to leave]
So telling a victim what to do is not helpful because it takes away their control and it prevents them from using choices, from exercising choice that up until now they have had no opportunity to exercise at all.
[slide on empowering patients]
So we begin consequently by making our goal of intervention empowerment. What does empowering the patient mean? We begin to empower patients when we share our observations, validate our perceptions with the patient and most of all when we listen in a warm and accepting manner.
[Scene of woman speaking with nurse in hospital.]
[Nurse Chez] What does that do? What exactly does that do? Some of us would feel that just listening wouldn't be enough. But in fact, validating and listening to the patient is a very powerful intervention from a nursing and medical standpoint.
It gives the patient the opportunity to validate with herself that in fact what's happening is wrong. It confirms her suspicions that maybe the pain that she's feeling is not necessary or right. You may very well be the first person to acknowledge that what is happening is wrong. And to give her permission to hurt, to be angry, to want to change and to seek help and support.
You will also be in a position to offer information and alternatives and educate the patient as to what the options are for her. To facilitate this experience, you'll want to try to be in a private atmosphere, an environment and to assure that the patient is alone.
[Scene of wife and husband talking with nurse in hospital.]
[Nurse] What I'd like to have Ms. Williams, I'd like to have you come in. And why don't you stay out here for just a few minutes Mr. Williams.
[Mr. Williams] We're here and that's why we're here, we want to get into a doctor.
[Nurse] Great. Great.
[Mr. Williams] And I'll bring her in now.
[Nurse] Standing. Well, I'd like her to wait out --
[Mr. Williams] Come on.
[Nurse] I'd like you to wait out here for just a few minutes, okay Mr. Williams?
[Mr. Williams] No. She needs me to be there with her. So I'm going to bring her in.

[Nurse] I understand. But generally our policy is to have visitors and the family just wait out for a few minutes while we get her settled and you know, have the doctor come in and examine her and --
[Mr. Williams] This is ridiculous. Honey --
[Nurse] Oh no, this is generally what we do. Really. You know, a lot of people have to come in here. We don't really have a whole lot of room and I'd like you to wait outside, but I'm going to come and get you. All right, is that all right with you Ms. Williams?
[Ms. Williams shakes head yes.]
[Mr. Williams] Honey, are you going to be all right?
[Ms. Williams] Um-hum.
[Mr. Williams] Give me a kiss.
[Nurse] Okay.
[Mr. Williams] I'll be right here. You let me know what's going on.
[Nurse]Okay. I absolutely will, Mr. Williams. Okay, come on.
[Nurse Chez] It was very important for me to have the husband wait outside. And sometimes that is a very difficult thing to do. To assure that the patient is private and to assure that the patient knows that everything that she says is confidential.
This may be -- you may want to try to use your visitor policy in your hospital to explain to any family members, including the husband, why exactly you want to have the patient alone. Such things as we need to do an examination or this is the hospital policy, are certainly acceptable. Unfortunately there are times when you may even need to use security. But you need to have the patient alone because you need to assure her that whatever she says is confidential. And if it is included in the chart, it still remains confidential and will not be disclosed unless she gives her permission. And that's important to make very clear.
[slide on intervention for the victim]
We begin our intervention most of all by asking questions which are direct and nonthreatening.
[Scene of Ms. Williams and nurse speaking in hospital room.]
[Nurse] Ms. Williams why don't you tell me a little bit about what happened last night.
[Ms. Williams] Uh -- sigh -- well, uh, it -- I really didn't feel as bad last night as I did this morning when I woke up. I -- I had uh -- my stomach really hurt and you know, just general aches and pains. I have a headache and uh -- sigh.
[Nurse] Um-hum. Well what happened last night that you felt -- said you fell down the stairs?
[Ms. Williams] Yea. I've been uh -- I've been so clumsy lately.
[Nurse] Okay.
[Ms. Williams] Actually I've always been clumsy.
[Nurse] You've always been. How long has that been going on? Or that you felt that way?
[Ms. Williams] Ahh -- a couple of years.
[Nurse] Oh. So what exactly happened last night?
[Ms. Williams] I um, I was standing on the attic stairs and I tripped and I fell. I fell backwards.
[Nurse] Did something startle you?
[Ms. Williams] No. I was just -- just my clumsiness. Probably.
[Nurse] Okay, where was your husband then?
[Ms. Williams] Uh -- he was in the attic.
[Nurse] He was in the attic.
[Ms. Williams] Um-hum.
[Nurse] And the stairs go to the top of the -- go to the -- right to the attic?

[Ms. Williams] Uh-huh.
[Nurse] Okay. But nothing startled you? You didn't get dizzy or anything?
[Ms. Williams] No.
[Nurse] Just tripped?
[Ms. Williams] Uh-huh. Yep.
[Nurse] All right. Ms. Williams I'm really concerned about you. And that's why we're here and that's why I want to talk.
You know, I kind of got the feeling when we were outside and I was talking to your husband that something else is going on. You seem very, very frightened and reluctant to talk about what happened. And he answered a lot of the questions.
[Ms. Williams] [sighs] -- oh uh -- I uh -- I'm -- I'm just -- I'm just scared to talk about it.
[Nurse] You don't have to talk to me. But I -- I'm just concerned about you. You know, I see that you're reluctant to talk about what happened and I just get the feeling there's something else going on at home. And um -- I know your husband was not happy that you had to wait. He seems very concerned about you.
[Ms. Williams] Mm-hmm -- He's a -- he's a good provider.
[Nurse] Were you having an argument at all? Or just --
[Ms. Williams] Well, he's uh -- he's under a lot of stress.
[Nurse] Mm-hmm.
[Ms. Williams] Um -- you know, I have two kids at home and -- uh, there's a lot of things to do. Sometimes I don't get them done on time. And you know I --
[Nurse] What happens then?
[Ms. Williams] Well it -- I just add to the stress of the situation, and, you know, he's -- you know he's done a lot for us as a family. And I just feel that sometimes I just don't -- can't uh -- keep up sometimes.
[Nurse] Well what happens when you don't keep up with things? Do you have a fight? Does he hit you?
[Ms. Williams] Well there's a -- you know there's a lot -- a lot of things going on and uh -- I have a lot of things that I have to do sometimes that I just don't get done.
[Nurse] And then you have a fight about it?
[Ms. Williams] We argue.
[Nurse] And does he hit you?
[Ms. Williams touches her face]
[Nurse] See the reason I'm asking is that you said you fell down the stairs --
[Ms. Williams] Mm-hmm.
[Nurse] And --
[Ms. Williams] Well, he's under a -- he is under a lot of stress and -- and I -- I just don't -- I sometimes I add to that you know, there are certain things that just -- that just should be done. And um -- sometimes I just don't get them done.
[Nurse] And what happens when that -- when you don't get them done? Does he hit you or do you fight about it?
[Ms. Williams] Well, we argue. We argue.
[Nurse] Is there anything ever physical going on?
[Ms. Williams] Uh -- I'm just -- I don't -- I don't know how to talk about it. I -- sigh -- where is he by the way?
[Nurse] Who?

[Ms. Williams] My husband.
[Nurse] He's out in the waiting room. You're -- I know you don't want -- you don't want him to hear any of this.
[Ms. Williams] He can't hear any --
[Nurse] Is that what -- okay.
[Ms. Williams] I don't --
[Nurse] You know nothing we talk about --
[Ms. Williams] Because I'm going --
[Nurse] Is he -- he's not going to hear anything that we talk about.
[Ms. Williams] Mm-hmm.
[Nurse] Everything you say is confidential because this is your problem. This -- I mean you're here to talk about what's going on with you. I'm not going to talk to him at all about it. And everything that's in the chart is confidential. Okay?
[Ms. Williams] So he doesn't hear any of this?
[Nurse] He doesn't hear any of this.
Okay. I'm concerned about you. I want -- that's why we're here. I want to help you. I want to find out what's going on. If you want to tell me. If you want to talk about it. Let me just ask you, did he push you down the stairs? Did that happen at all?
[Ms. Williams] Uh -- well there was -- there was really no step there and uh -- I just -- I fell backwards and --
[Nurse] Did he push you? Backwards?
[Ms. Williams] Well the door sort of uh -- the door was there and it sort of closed and uh -- I just fell backwards.
[Nurse] And did he know you were standing there?
[Ms. Williams] Well uh -- you know, this --
[Nurse] Do you think this was intentional?
[Ms. Williams] There -- he doesn't -- he didn't really -- he didn't realize that there was no ledge there. You know, there was really no real step. There was just -- it happened really quick. Happens. People argue.
[Nurse Chez] Those are just a few examples. Know that there's again no right or wrong. What's important is that you ask the question. And if all you ever receive is a no and a refusal of the patient to -- to validate that this is in fact true and the patient ends up leaving the hospital, know that you have planted a seed that may be true. And at some point this patient is going to go home and think about what you asked. And know that someone at some point cared enough to ask. If the answer is yes, as we've been taught throughout our practice, you'll want to listen. And listen very carefully for what you're hearing. Again, all it takes is a simple act of empathy to help the patient start the cycle of action, or subsequent action on the victim's part.
[scene of Ms. Williams and nurse speaking in hospital room]
[Nurse] Did you know that violence against women is a common problem? It's something we see here a lot?
[Ms. Williams] Well, what happens to these women?
[Nurse] Sometimes they come because there are injuries and sometimes just to talk about what's happening. And we usually give them information.
[Ms. Williams] What kind of information.
[Nurse] There are lots of alternatives. What kind of information?
[Ms. Williams] Mm-hmm.

[Nurse] Well, there are phone numbers. There's a hotline that you can call to talk to counselors that are trained and they can give you some information. The kind of options are to -- sometimes women decided to leave the situation and there are places that you can go.
[Ms. Williams] Uh --
[Nurse] If you want to. You know, this is against the law. It's against the law to hurt a person this way. And there's not anything that you did or could have done to deserve being hurt this way.
[Ms. Williams] Well he doesn't mean to.
[Nurse] But he does. I mean, is that true that he does?
[Nurse Chez] That is an important interviewing technique. If you don't have the time to listen, what can you do? Many of us are very, very busy. We have multiple patients to take care of. So it is understand -- it is understood that if you don't have the time to interview a patient then you need to explain that to the patient.
The problem is that very often we try to help patients and we say that we can listen and then we're anxious about the fact that we've got other patients to take care of. You try not to -- you want to try not to sit with a patient and look at your watch and be impatient.
[scene of woman speaking to nurse]
[Nurse Chez] What would that mean to a person who's no -- who no -- for whom no one else has listened? Well that would mean again that perhaps she was being rejected. So you need to be very careful about being honest and refer the patient to someone else in the hospital.
In most hospitals the Social Work Department is the perfect place to refer the patient. Sometimes the patient has a very good rapport with her physician. That is the patient's choice. So you'll need to ask for their permission and if they will agree to talk to another person. But be very honest about why you cannot listen to her.
[slide of a phone number help line, 1-800-572-7233]
There are additional strategies for help. For example there's a national hotline number that is open 24 hours a day, 365 days a year. And the counselors are trained to be very, very helpful in assisting the patient. Not only counseling them, but giving them information. There are brochures. There are safe help homes. We'll talk about some of the community resources.
[image of brochures]
In terms of brochures, many healthcare facilities prefer to leave these brochures out in the waiting room, that's a possibility. Some patients are embarrassed to have to pick up a brochure such as that. You may want to leave them in the bathrooms where there's a more private area. In addition, you can hand out these brochures. You'll need to look into what brochures are available in your hospital. Each area has -- there are separate writings.
[slide on intervention for the victim]
Community resources are also in abundance. Specifically, there are -- is emergency housing such as welfare rooms or homes. There are safe home networks. There are places which will suggest to a battered woman that she come there and never tell you or anybody else that she knows about them, so that she can go in a secret manner, privately and not be found. And that again is the woman's choice.
What you need to do is encourage her to make those phone calls because the counselors will be able to tell her where these areas are. The emergency housing will provide counseling, maybe legal advocacy, child care, any of those types of facilities are available to them.
Counseling is also a very helpful step that can come in the form of peer groups, private counseling or just simply the hotline numbers. And that again is the patient's choice. The

national hotline number will again be helpful in assisting the patient make those decisions as to what type of counseling would be most beneficial.
There is also legal assistance. Many judges and police are -- have become more sensitive to the issues concerning victims of domestic violence.
[scene of police arresting man]
In fact in some States police are able to go in and make arrests based on probable cause at their own discretion. So that is an opportunity as well.
Remember that involving the police in a domestic violence victim's situation in the hospital is always the victim's choice. Again we want to give as much choice to the victim. We want to try to take over -- try not to take over and make those decisions. So involving the police is always the victim's choice.
Photographs may also be helpful. Remember that when you're taking photographs of an adult patient it needs to be based on consent. In some hospitals there's a consent form that may be helpful for the victim to use, or patient at this point.
Then you'll need to obtain consent in the appropriate -- based on the appropriate policy that your hospital uses. In many hospitals there's a photography department during the day and sometimes security at other times may be able to take photographs. You'll need to look into what the policy is in your hospital.
If you do not have a consent form available, know that it is very important to document that the patient requested or agreed to photographs. These will be used in the future if there are legal proceedings.
When you do take photographs, try to take photographs of the hands or the face. And always date them and time them on the back of the photograph, including the patient's name and history number. Then place them in a sealed envelope and keep them in the chart. Certainly you'd want to try to get only visible trauma. Photographs are particularly helpful in that case.
If the patient returns to an unsafe environment, which is very often the case, they will return especially if this is the first time that you have brought the subject up or the first time that they have ever had assistance offered to them.
[scene of nurse talking to Ms. Williams in a hospital]
[Nurse Chez] Understand that for many of us as -- again as people who offer help to patients all the time, it is very frustrating to watch someone go back to an environment which we are fearful is dangerous.
Understand that you may be frustrated, but that your asking and your intervention so far has been immeasurably important. The victim did hear you. She heard you and she will think about what you've said.
Also know that she is a survivor. And very often we tend not to even call victims anymore, but survivors. She has survived the abuse this far and will continue to survive and will know exactly when it is safe to leave and make decisions about on her own behalf.
Communicate with the patient that it is a difficult time and that you want her to make the choice. And that it is all right that she return -- whatever choice she makes is okay. Allow the victim to make the proper choice on her own behalf. And avoid the need to rescue and limit.
So far we have talked about the adult victim and you empowering them or offering them choices so that they can take control over their own lives. We are now going to talk about the intervention for the child.
[scene of a young girl playing]
What specifically do we need to do to intervene so that the child is not in danger?

Recognize that concerns regarding child abuse are very broad and differ somewhat from the adult victim. If I was to talk about child abuse in its entirety, it would be a great -- it would require a greater time frame. So I'm just going to focus specifically and briefly on how we would want to intervene in the case of child abuse as it related to violence in the home.
[slide on general indicators of child maltreatment, abuse or neglect]
There are some additional indicators as I said before. Those indicators are delinquency in a child, truancy, in other words the child does not attend school. Head trauma is a classic finding in child abuse.
There are also behavioral indicators. And in those indicators you need to think about how you would expect a child to act who is being abused. Mostly we would see children who are wary of contact with adults. Children who are afraid when they hear other children cry because usually they're hit for that kind of behavior.
Behavioral extremes. Children who are involving attention getting maneuvers or who are extremely adult like or extremely immature. Those are just a few of the behavioral extremes aside from the ones I mentioned before with the adult victim, which would be withdrawal or multiple nonspecific complaints, those are also found in the child.
[slide on signs of sexual abuse]
You also may see signs of sexual abuse. And in children -- a child who comes into you with venereal disease is a big clue that they have been abused sexually. Children who are of a young age who are using advanced knowledge regarding sex, parts of the body or who are trying to involve other children in the sexual acts are also indicators in and of themselves.
[slide on signs of neglect]
We also look for indicators in terms of neglect or children who fail to thrive for example. Or who are not reaching their developmental milestones. Are they not speaking when they are supposed to? Are they not walking? Are they sucking their thumb at a late stage in life for example?
Also children who have unattended needs medically. We see this a lot when children are brought to the hospital and have old injuries or if their immunizations are not up to date. Those are just some of the examples that you would see if the child was being abused in a primary manner in terms of direct abuse, direct assault or direct verbal, emotional and physical abuse.
[slide on secondary victimization]
Children are victims of primary abuse, but they are also what we call a secondary victim. What is a secondary victim? A secondary victim is someone who witnesses the abuse or the effects of abuse on someone that they love.
The result of abuse from that perspective is that the child often feels stress. It's a very stressful environment to be living in an area which some may want to call a war zone.
[scene of a young girl with a bruise on her leg playing with doll]
As a result of the stress you may see specific behavioral characteristics in the child's behavior such as embarrassment. They may be -- have feelings of guilt or shame. There may be behavioral extremes as well from -- directly from the stress that they are feeling.
In addition, children are secondary victims in the sense that they learn that violence is a norm for them. Remember that the family is a very powerful educator. Children in this setting learn that in fact love does really hurt in some instances. And they grow up feeling that violence is normal and that is how sometimes we have -- end up having battering adults.
[scene of nurse talking with Ms. Williams in a hospital]

[Nurse Chez] So it's important to know that when you're talking to a battered woman who has children at home that although the children may not be directly hit, they too are feeling the effects of the violence. They may not exercise it now, but they may choose to talk about it later on in their life and they may actually act out that behavior. Some day it comes out in some way.
To intervene in the case of child abuse remember that in many states, in most states it's a law that child abuse needs to be intervened in some way. Mostly in terms of reporting it. And most often this is while you are in a professional capacity.
So it is while you are working that you are mandated to report. You'll need to know what the policy is in your hospital and also the law -- what the law is in your state. You may want to look into that.
But know that in most cases the reporting procedure is as follows:
[slide on the intervention of child abuse]
The first thing you'd want to do is to identify in your hospital whether you have a child abuse team or a child protection team. In many cases this team will come to the area that you are located and begin to intervene.
If you do not have a child protection team or even if you do, you may want to confirm you suspicions with your peers. Most of all you'll want to make a phone call. In most States there is a central registry specifically designed for child abuse. You'll need to know the number. It is usually or most often a 1-800 number.
Following a telephone call you will be asked to complete a written report. The written report will ask you to confirm a lot of the information that you gave on the telephone call. Some of that information will concern the child, the abuser, and they will also ask questions about you. How you -- what is your name, your responsibility, what you have done so far as a healthcare professional intervening in this case, and how you can be reached.
The written report needs to be written anywhere from 24 to 48 hours following the telephone call. You'll need to know again, what is the law in your state. It is very important to follow up with a written report, otherwise it's possible that the case will be lost.
Sometimes within minutes of a phone call, depending upon how dangerous the case is, there may be a case reporter sent out to the house. So it is critical that you make that kind of phone call.
[photo of an abused girl]
There is also additional protection. Remember that when we talked about the adult patient we mentioned photographs. In the case of child abuse you would want to handle photographs the same way. The only difference is that you do not in most cases need consent. The law protects children. Therefore, we do not ask for their consent to take photographs.
[photo of an abused boy]
There are also services in your local community called child protection services or emergency children services which will come into the hospital and make a judgment based on the case as to the likelihood of further danger. And make the decision of whether the children that are in the hospital and those who are left at home will need to be removed from the home. They will then be placed into foster homes through the local protection agency.
So it's important that if you are in fear of the child's safety that you make the phone calls to your local protective agency. There are some legal and societal concerns that many of us have as reporters, particularly if we choose to give our names over the telephone call through the telephone reporting system. Know that you are granted civil immunity from any kind of liability, civil or criminal, because you have acted in good faith.

Your call is also anonymous. So basically there is no reason not to make the phone call. On the other hand, if you do not call when there is reasonable cause to suspect, in many states you are liable for criminal -- for charges and for the danger to the child based on reasonable cause to suspect.

In summary, the problem of domestic violence is complex and many-faceted. We have reviewed the problem as it stands and intervention strategies. Although it is tempting for most of us to want to help the person immediately and have them remove themselves from the dangerous environment immediately that is not really realistic.

We have helped though. And you can help by following the guidelines I described.

[slide on a nurse's role of intervention]

Specifically, you identify the abused patient. You acknowledge that the abuse is wrong. And you validate your perceptions with them and your observations.

You offer your nonjudgmental support and information regarding alternatives. And most of all, you'd want to report all suspected child abuse in addition to the other interventions you've provided for the adults.

[music]

Most of all you can remind yourself and the patients that you take care of that we all have rights as human beings.

[video collage]

We have the right to have respect. The right not to take responsibility for anyone else's problem or bad behavior. The right to get angry. The right to make choices. The right to say no.

To have our own feelings and opinions. To negotiate for change. To protest unfair treatment or criticism. And the right to live.

[Text on screen] Special thanks to: The New York Hospital - Cornell Medical Center, New York, New York. Patty Sweeney, RN, Theodore Angelus.