

[Narrator] Emergency departments see various forms of abuse every day. For the next 90 minutes we will be discussing some of the reasons for abuse and how to recognize the abuse victim. We will also cover possible intervention measures and the legal aspects involved. The program will focus on spousal and elder abuse, although commonality with children abuse will be addressed. You will also have the opportunity to call in with questions you may have concerning the material covered. Join us next for "Caring for the Abused, Domestic, Spouse and Elder."

[Text on screen] Emergency Nurses Association]

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Caring for the Abused: Domestic Spouse and Elder, featuring Dan Sheridan R.N., M.S.N.

[Jim McGraw] Hello, and welcome to Dynamics in Emergency Nursing. I'm your host, Jim McGraw. By now you should have received a copy of the participant guide which outlines the presentation. If you do not have a copy, please check with your site coordinator to obtain one. Our objectives for this seminar are to enable you to recognize physical and psychological signs of abuse, to describe several legal aspects of abuse, to state key documentation guidelines related to abuse, to recognize non-traumatic indicators of abuse and to describe several assessment and intervention strategies.

I would also like to remind you that you will have an opportunity to call us with questions you may have concerning the material covered. The number you see on your screen is the number to call during our question and answer period. This will be the last 10 minutes of our program.

Our presenter on abuse hails from Oregon. Dan Sheridan is a family violence consultant and clinical nurse specialist at the Oregon Health Sciences University Trauma Program in Portland, Oregon.

Dan has authored numerous articles related to family violence and given over 200 professional presentations. He is an internationally recognized speaker on the topics of battered women, child abuse and neglect and elder abuse.

Welcome, Dan. Let's start with some definitions. How do you define abuse?

[Dan Sheridan] Well, first of all, thanks for having the opportunity to have me on the show today. I'm going to start out with the definition of family violence in its broadest sense.

Family violence is in essence when one family member is abusing another family member. For some families it could start in utero where you have an abuse of a pregnant mom going on. The child is born. You could have child abuse and child neglect. That may then go on. You can have spousal abuse or domestic violence. And in that same family under that same roof you could have elder abuse. So when you talk family violence, you're trying to looking at throughout the life cycle. And that's a little different.

You'll hear people talk about spousal abuse, which is often used interchangeably with domestic violence or domestic abuse, but probably the preferred term is intimate partner abuse. When you start talking about spousal abuse, in essence what you're talking about are intimate partners. Spousal assumes that there's marriage going on and - and domestic doesn't really quite describe it. So most people tend to prefer that as - as intimate partner abuse.

And that is again separate from elder abuse, which again is this broad category that can describe multiple forms of abuse that are occurring to the elderly in the home. That could be physical abuse and it could be psychological abuse, it could be neglect, it could be passive or - or active abuse. It could be financial abuse. Some people also talk about elder maltreatment instead of elder abuse. So you'll hear a lot of those terms in the literature.

[Jim McGraw] So we're talking about a wide range of - of behaviors here.

[Dan Sheridan] Yes.

[Jim McGraw] Do we have any general understanding of what the - the cause or genesis of this problem is?

[Dan Sheridan] The best theories at this point do not view family violence as a disease, do not view it as a - a pathologic problem. They view it as a learned social behavior that has been sort of couched in a patriarchal society that has legalized and sanctioned violence throughout at least the course of our country's history, and even earlier than that.

For example, have you ever heard a speaker use the term "rule of thumb?" A good rule of thumb to follow whenever you're starting an IV or doing a dressing change. Well, the etiology of that term is based on Colonial American law where I had the right as a husband to physically chastise my wife as long as I used a stick no wider in diameter than my thumb, hence the term "rule of thumb."

There was still a interesting law on the books in the 1970s; a small town in Pennsylvania, that gave me the right as a husband to physically chastise my wife as long as I did it before 10:00 at night and I couldn't do it on Sunday. Now there was logic to that law because of course if I beat my wife after 10:00, her screams would be disruptive to the neighbors. And of course Sunday being the Lord's day, the day of rest, of course I couldn't beat her on that day.

So we - we say where are all these battered women coming from? Where are all this elder abuse coming from? Violence in the home has always been there. Women and children and then elderly, who are often viewed as children in some homes, were considered chattel, considered property of the man of the house. So, it - I mean, it's - it's just based in that learned social behavior.

[Jim McGraw] Is - is family violence, as you - you describe it, is it a big problem, small problem, growing -

[Dan Sheridan] Okay.

[Jim McGraw] - problem?

[Dan Sheridan] It's a major problem. It is probably one of the principal or one of the largest public health problems affecting the nation today. In a few minutes we'll get into some exact statistics. But let's just kind of review some of the - the incidence of - of domestic violence first. About 95 percent of domestic violence or spousal violence or intimate partner abuse, whatever you want to call it, is violence being perpetrated by men onto women. About two to three percent of spousal violence is violence where the woman is the abuser and he's the battered man. Another two to three percent is gay and lesbian violence or violence within homosexual couples. We're going to be primarily talking for the rest of this afternoon on violence that is occurring against women being perpetrated by men.

When you look at elder abuse, probably the majority or at least over half of elder abuse is violence against elderly women being perpetrated by her spouse. She's been married to this abusive man 20, 30, 40-plus years. And it's a very measurable part of it. Another measurable part of elder abuse is violence being perpetrated by adult daughters or adult daughter-in-laws onto elderly moms. And that makes sense.

First of all, we have a larger population of elderly moms to be abused because women tend to still outlive men. And then if a elderly mom needs home health care or - or - or stuff, nursing at home. It's usually the daughter or the daughter-in-law who inherits the care of that, not so much the son. But when we do look at elder, physical elder abuse, we do find that there are a fair

amount of sons and sister-in-laws who are physically abusive, whereas the daughters and the daughter-in-laws tend to be neglectful of that elderly people.

[Jim McGraw] Nationwide how - how - what sort of numbers do we have about how frequently this is a problem?

[Dan Sheridan] Well, I have probably been accused on more than one occasion of being somewhat of a - of a liberal on many issues, especially these issues. The numbers I'm going to share with you are based on FBI data, and the FBI has been accused of a lot of things over the years, but never of being a liberal organization. So I'm going to say these numbers are probably conservative numbers at best.

The FBI estimates that there are some

2 million cases of child abuse and neglect each year in this country. Some 2 to 4 million women are physically beaten every year in this country. The American Medical Association estimates 8 to 12 million women are at risk for abuse. And by "at risk," what it would mean is let's say for example tonight I go home. My wife and I get into an argument. I have her up against the wall and I put my fist through the drywall one inch from her ear. She wouldn't be part of that 2 to 4 million battered women, but she certainly would be at risk at abuse.

Elder abuse. About 1 to 2 million elderly people are being abused. And the abuse almost always escalates over time to the fact where a significant percentage of the murders in our country are domestic homicides. In fact the best estimate is that about half of all women killed in the country are killed by a boyfriend, an ex-boyfriend, a husband, an ex-husband. And that means about 3,000 women die every year in domestic homicides.

About 25 percent of the male homicides

are domestic violence-related. Many of those are battered women who are killing their abusers and they see that as the only way out of the abusive relationship. So domestic homicide certainly is a significant, significant problem. And in fact there are three times more women are hurt in domestic violence; and that's elder abuse and battered women combined, than they are in motor vehicle accidents. Three times more women. And yet we as a society have spent billions of dollars; well spent, on motor vehicle safety, drunk driving laws, seat belts, air bags. We have hardly spent a dime on the single largest cause of injury to women, injury in the home, domestic violence.

[Jim McGraw] What about from the perspective of the ED nurse? What - what - what portion of his or her practice can he or she expect to be battered people?

[Dan Sheridan] There is some conflicting data out there. Stark & Flitcraft have done some wonderful studies out of some Yale-affiliated hospitals that show that maybe as high as one in four women with trauma, no matter what they may have told the - the paramedics and triage nurse, the ED physician, no matter what they may have initially said, they were there because of domestic violence. Most studies are showing somewhere about 1 in 10.

One in two serious traumas could be domestic violence-related. And by "related," what I mean is it might come in as a pedestrian versus auto, hit and run, but at six months later the police find out it was her first husband who was driving the auto.

Where it might come in as a single car accident; a woman drives a car into a tree 60 miles an hour, no skid marks, we think maybe suicide attempt, and it probably was. A battered woman is more likely to try to kill herself to get out of an abusive relationship than she is to kill her abuser. About half of women in shelters who have been studied readily admit that they have seriously thought about killing themselves in order to get out of abusive relationships.

The - probably the most significant number for ER nurses to be aware of is the battering during pregnancy. As many as one in six pregnant women are being beaten while pregnant. And we're going to be going through some of the complications of pregnancy, but I think every pregnant woman who comes through the ER must be assessed.

[Jim McGraw] What are the - the different kinds of -

[Dan Sheridan] Okay.

[Jim McGraw] - of abuse? What are the ways people are -

[Dan Sheridan] Sure.

[Jim McGraw] - injured?

[Dan Sheridan] When you talk about adult family violence, battered woman, elder abuse, probably the easiest symptom are the physical symptoms.

[Image: Types of abuse]

Those are the easiest to identify. It usually starts out with some pushing and some shoving, some slapping and it - then it pretty rapidly escalates into choking, punching, kicking. Now you begin to see some physical sequelae. You're going to be seeing some bruises. You're going to be seeing some scars. And then there's going to be use of weapons, objects as weapons.

So the physical abuse is probably the easiest to identify. But battered woman will be very quick

[Footage of a man abusing a woman]

and elder abuse survivors would be very quick to tell you that it's the emotional and psychological abuse that is the most frequent and hurts the most. That is the most painful. The constant name calling, the swearing, the belittling in front of friends and family and - and - and the public, harassment tactics such as stalking, ripping up their clothes, destroying a - a prized heirloom right in front of them, destroying something that they know will hurt. Slashing tires on cars.

Isolation. What you'll find in all forms of family violence, child abuse through elder abuse, is these families tend to be socially isolated. So you'll find that.

[Text on screen] Types of Abuse: Emotional/psychological: Name calling, Public embarrassment, Harassment tactics, Sabotage efforts to advance, Insidious to forced isolation, Threats, Destruction of personal property

And I put that under psychological abuse because that's - that's a lot of that. The mind games go on there. The threats of abuse. All of this leads to a gradual destruction of the self-concept of the battered woman or the elder abuse survivor.

Sexual abuse is another category very, very common with battered woman.

[Jim McGraw] Before you go on, Dan, I noticed that on the screen they - the - our viewers could see some of these other emotional forms of abuse. And - and there was sabotage efforts to advance. And I'm not sure -

[Dan Sheridan] Okay.

[Jim McGraw] - I understand that one.

[Dan Sheridan] What frequently happens is battered women will try to go to a community college, finish their degree, go through some job training and he doesn't want her out of that home. He wants to be able to control her. So he'll destroy her books or he'll create a crisis that then doesn't allow her to attend class. There's some problem that comes up. So he - he'll purposely - and it's - "purposely" is the word - he'll purposely choose behaviors that prevent her from gaining independence from him. And that's what I mean by sabotaging the efforts to advance. Good question. Thank you.

[Jim McGraw] Okay. I interrupted you when you were talking about sexual abuse.

[Dan Sheridan] Yes. Any time you've assessed a positive history of physical or psychological abuse against a battered woman or even an elder abuse survivor, you must be assessing for the potential for sexual abuse. And we'll have some sample questions we'll get to in a few minutes. But about half of battered women in shelters report when it comes to sex with their abuser, no does not mean no. If he wants it, he takes it. And if she doesn't give it, she's beaten.

[Text on screen] Types of Abuse: Sexual: Violent sexual assault, Forced/coerced sexual acts, Withhold

I've worked with many women, women who have been severely beaten and then they've been rectally or orally sodomized after the beating. I've worked with women where he withholds sex. He uses sex as a weapon. He withholds sex. Women have said to me, Dan, I haven't slept with my husband in two years. He says things to me like I'd rather sleep with the dog than have sex with you. I'd rather masturbate than have sex with you. He's using sex, withholding it as a weapon of control over her.

And one of the things that we're - we are just as a society probably not ready to accept, but it's true, is that many elderly people are being sexually abused, sexually assaulted in their homes by family caregivers. And we need to be aware that that's happening and ask the questions.

[Text on screen] Types of Abuse: Economic/financial: Forbids survivor to work, Gets survivor fired, Limits access to money, Nothing is in survivor's name, Refuses to pay bills, Ruins survivor's credit history, Does not pay child support

Probably the last category is economic abuse, and this is really probably one of the most prevalent ones in elder abuse is where a family member; and usually this then becomes the children or the grandchildren, are economically taking advantage of that elderly person or forcing them to sign over their assets to them. That's probably one of the critical ones in elder neglect or elder abuse is the financial.

But battered women are also financially trapped in the relationship. If she's working, she may have to hand all the money over to her - to the abuser. He may not - not allow her to work. I've worked with a lot of nurses who have been fired from their jobs because they're in abusive relationships. And how it usually plays out is she's working 7:00 to 3:00 shift. There are three call-ins on evening shift. She agrees to do a double. She leaves the phone message, honey, you got the kids. He shows up at 9:00 with the kids, drops them off in the ER, says I had plans tonight. They're your kids. You figure it out. They get into a big argument right there in the hospital. He beats her up. Administration says we can't have this. She gets fired. Okay. So nurses certainly are not immune to abuse and I've seen that played out over the years.

He may ruin credit histories. Doesn't pay child support. All that economics may help keep her trapped in that relationship.

[Jim McGraw] I've noticed an interesting thing so far, Dan. Several times you've referred to the people who have been abused as survivors of abuse -

[Dan Sheridan] Yes.

[Jim McGraw] - as opposed to victims of abuse. Could you explain what - what you're doing with that?

[Dan Sheridan] Yes. And there's some debate within the domestic violence community about this, but more and more people are beginning to say survivors of family violence are exactly that. They're survivors.

Think of yourself, for example, if you board a plane and you're going to fly from here to Seattle and that plane goes down, what would you want to be known as, the victim or the survivor? We in the health profession and an ED nurse, as - as an ED nurse myself, we - we tend to characterize a lot of people as victims. We have heart attack victims and we have AIDS victims and we have child abuse victims. And we think of victim, we think of someone who's helpless and hopeless and we have to come and do things to them. Battered women, elder abuse survivors are not victims. They're not helpless. They are surviving their abuse. I come in as a clinician and I work with them as survivors. I don't do things to them as victims.

[Jim McGraw] That makes complete sense. Where does the law fit into all of this? I would think that there'd be some law to help protect people from this sort of problem.

[Dan Sheridan] There are. Every single state now in - in the country has passed domestic violence legislation, and most states have elder abuse legislation. In addition, there's Joint Commission requirements. And we're going to talk about them in that order.

I think it's real important for the emergency room nurse to have a working knowledge of criminal statutes that apply to domestic violence. For example, in probably 35 states if I were to reach out and hit you right now, which I won't, but if I were, it would be considered a battery. In some states, however, that same act is called an assault. If I were to threaten to hit you, in some states that's an assault and in some states that's menacing. In some states if I hit you but didn't cause an injury, that's harassment. Some states require mandatory notification of the police for any crime victim that comes to the ER. You must know those statutes in your state. Some states you could have people who are shot and stabbed and you don't have to call the police. So I think you have to have that working knowledge within your own state of what these laws are.

You need to know that elder abuse survivors, battered women, family violence survivors are all eligible in every state for domestic violence statutory relief usually through the form of restraining orders or orders of protection or protective orders. They're called three different things in most states. And they can get these free of charge by filling out a form and - and this can order the abuser out of the home. Instead of her having to go to a shelter, they can order him out. Can give her temporary custody of the kids.

So you need to be aware of is there mandatory arrest in your state? For example; this happens a lot in EDs, the abuser brings in the patient. She's in the back getting sewn up. He's out in the waiting room having a cup of coffee and reading a magazine. Well, if there's mandatory arrest in the state and the police are called and he's hauled off to jail - now, I've seen it where he's made bail and he's back in the ER now angry and she's still in the back being treated. So you need to be aware while there's mandatory arrest, you have to come up with a safety plan if you're going to have him arrested out of the ER. And we'll talk towards the end more about safety plans.

The Joint Commission in 1992 passed some of their requirements that required emergency rooms and ambulatory care settings to have specialized training and protocols for all forms of family violence. In '94, so this year, they've changed it. So these have to be hospital-wide. And what those requirements are is that there have to be protocols and policy procedures throughout the hospital to deal with child abuse, spousal violence and elder abuse. All three forms have to be taken care of in these protocols.

There has to be training of key personnel. And obviously emergency room personnel are key personnel. There need to be up to date referral cards, referral packages available throughout the hospital, throughout the medical center. There needs to be comprehensive documentation in the medical record.

It's not just good enough to assess it. It has to be well-documented. And we'll talk in a few minutes about that.

We have to be - opportunities - we have to be well-documented. How are you going to maintain that chain of evidence, because these are criminal cases and more and more so these cases are entering into criminal courts of law and there has to be standards for chain of evidence. And also they highly recommend, but they don't mandate - they highly recommend that photographs be taken of these injuries, because usually if they do go to trial, it's months later and the injuries have healed. So having the availability to take photographs as needed and with consent is real important.

[Jim McGraw] Well, Dan, I'm - I'm sure I speak for a fair number of people who say when they hear these descriptions, y'know, this is terrible. No one should have to endure this. But, golly, why doesn't she just leave?

[Dan Sheridan] Okay. That is probably one of the most frequent questions that I'm asked. Why would a woman stay? Why would an elder abuse survivor stay in an abusive home? And I have come up with what I call sort of the - the eight Fs. And battered women and elder abuse survivors hear the F-word, which we can't say, all the time. That is part of that verbal and psychological abuse that goes on. But these are words that you can say in public and - and they're sort of in a priority list, but not necessarily absolutely prioritized.

Probably the number one reason a woman stays or an elder abuse survivor stays is fear because that abuser has said real clear if you leave, I'll kill you. If you leave, I'll kill you and the kids. Or, you might be able to hide from me, but I know where your sister lives. I know where your mother works. Fear is probably the number one reason. And when you look at those homicides we talked about earlier, those 3,000 battered women killed every year, almost every single one of them was in the process of leaving when they got killed. So leaving is the most deadly time.

Finances. Finances keep people trapped. Family. Family pressures. Family pressures to make it work. Family pressures that maybe her mother has bailed her out 100 times and - and each time her mother gets her window shot out or her tires slashed and her mother says I'm afraid.

Family for the elderly is that maybe she doesn't have family that live anywhere near. Her kids are grown and they're living multiple states away, so she has limited access to family.

For battered women, father is a real important word. She doesn't want to be one of those moms, those single moms. And she stays and she'll say, well, he's really good to the kids, so I'm staying because, y'know, I want my kids to have a father and he's really good to them. What motivates a lot of women to leave is when his abuse spills over to the children.

For some women this next one is more important than fear, and that's faith.

A very strong religious belief that marriage is through life, through good times and bad 'til death do them part. And for some women and for some elderly abuse that's when they do leave.

For some women it's forgiveness. A real common pattern has been identified by Lenore Walker and others is that after an abusive episode abusers frequently shed real tears, they promise never to do it again, they'll get help, they're sorry. And for a while they turn into that Prince Charming that they were at the very beginning. So they weren't psychologically abusive on that first date or there wouldn't be a second date. So they - and then she doesn't want the relationship to end. She wants the violence to stop. So when he says he's sorry, she forgives him.

She stays because fantasy. She has this fantasy that if she only works a little harder, it'll get better.

And she stays because of fatigue. She - he has just worn her down. She is just too tired to leave. That elderly person may be just too exhausted to try to break out of the violence.

[Text on screen] The Eight F's: Fear, Finances, Family, Father, Faith, Forgiveness, Fantasy, Fatigue

[Dan Sheridan] But even when women - or - I say women as a general term - are ready to leave, it's my understanding that frequently they get that far and then -

[Dan Sheridan] Yes.

[Jim McGraw] - things don't work the way they would've hoped.

[Dan Sheridan] Historically - the systems that are there to help elder abuse survivors and battered women historically have not done a very good job in helping. Historically. Now, all of the systems are beginning to improve. For example, the police. The police historically were trained to come to the scene of a domestic, to calm things down, to talk to the couple, to separate the couple, to walk him around the block, cool things off and then to leave. They viewed it as a civil problem. They didn't view it as a criminal problem. They viewed it as a civil problem.

[Footage of police talking to abusive man and battered woman]

Now then of course the minute that they would leave he would come back in.

The abuser would beat her up for calling the police in the first place. The police departments are getting better all over the country. Many cities now have specialized domestic violence intervention units. So the police in general are getting better. That doesn't mean that they're all perfect. It doesn't mean that there aren't communities where the police are not supportive. But in general they are getting better.

Criminal courts used to view this as a civil problem and civil courts used to view this as a criminal problem. Now they're beginning to say this is a criminal and a civil problem and they're beginning to create what they called unified courts where they're dealing with both the civil matters and the criminal matters in the same court room instead of having that battered woman like a ping pong ball going between courts. So these unified courts are beginning to pop up around the country.

Child protective services used to hold battered women accountable for allowing the abuse to happen. They would do nothing to come up with a plan that would protect the woman and the kids, but they would hold her accountable for allowing him to abuse the kids and then they would punish her because he was abusing the kids and he would get away virtually scot-free. But child protective services are beginning to say, gee, let's work with the battered women's community with a plan to protect mom and the kids.

The health care system, in my early days as an ER nurse, we used to treat and street battered women. Bring 'em in; bring 'em out. We - she would come up with some history that we knew couldn't be true. We knew it, but we'd never question it. We'd sew her up. We'd X-ray her. We'd put the cast on and we'd say she'll be back next pay day. She'll be beat up again. Now, the health care system is rapidly beginning to change and improve its care of - of battered women and elder abuse survivors.

[Jim McGraw] So what finally causes the - the - the abused person to leave?

[Dan Sheridan] Usually what happens is when the abuser is no longer remorseful, when the survivor learns what their options are - and a large part of what I do is I provide patients information. I provide them resources, referrals and advocacy. And I also reframe questions for staff. I like to reframe the question. Instead of saying when does she leave, we need to begin saying why does he abuse? If we were to say to a rape survivor why were you out at 2:00 in the morning wearing such a skimpy outfit? Why did you accept a ride home from this party with

this guy you'd only met once or twice? And then the woman's raped. We would say those are victim blaming.

When we say to a battered woman why do you stay, are we not victim blaming? What we need to say to men is why do you abuse? And we also need to tell women that they can get out. And when you look at the statistics - Jackie Campbell did a great study when she was at Wayne State University, a nurse researcher, and she looked at 100 women getting out of non-abusive relationships and she looked at 100 battered women who were getting out of abusive relationships. And lo and behold, there was no difference in the amount of time it took to leave. It seems it takes most women five to seven times of leaving, making up, trying again, leaving, making up, trying again. And most of us have been in a relationship where we'll say, ya know, in retrospect we should have known the first time this wasn't going to work. But it seems there is no difference. But when a battered woman leaves, it could be very dangerous. When that elder abuse survivor tries to leave without support and a safety plan, it's very dangerous.

[Jim McGraw] Why do abusers abuse?

[Dan Sheridan] They abuse because - if you look at it as a power and control model, they abuse because it works. It gives them a sense of power. They have a need to control this individual and abuse - abuse is the way that they use to control that. And it's - it's - like I say, it's not a disease. It is not a - a - a syndrome. It is just a learned social behavior. And a lot of men actually say I didn't do anything wrong. I only slapped her around a bit. In fact, she made me so angry, you know, she's lucky she didn't get it worse.

Now, maybe I'm sounding a little bit like a male basher, and I am, but only to those men who choose to be abusive. See, it is not an anger control problem or an impulse control. It is a choice. He chooses to be abusive.

Now, in defense of my Y chromosome, I have worked with some battered women who probably would anger the Pope. They can be a real challenge at times to work with. But because a woman's personality might make you angry or me angry, it would not give either one of us the right to beat her, to rape her, to literally keep her a prisoner in the home. So the right to be angry at a woman is a much different debate than the right to abuse. And I believe wholeheartedly that no man has the right to abuse a woman for any reason. There is just no excuse for abuse at that point.

[Jim McGraw] At this moment I'd like to remind our viewers that at the - near the end of our program we will have the opportunity for you to call in your questions to the number you see on the screen, and the number that you see on the screen is the one to call. Now would be a good time to call. And we'll get your questions in a little bit.

Dan, we've talked about what the problem is, how prevalent it is, how serious it can be, why it happens. But in the shoes of the ED nurse who's gonna be in the ED tonight, gonna be faced with an onslaught of people with a variety of problems -

[Dan Sheridan] Okay.

[Jim McGraw] - how does he or she ferret out the people who really have this problem -

[Dan Sheridan] Okay.

[Jim McGraw] - especially if they're trying to hide it?

[Dan Sheridan] Well, first of all, you need to assess for violence in private settings. Not at the busy triage desk when there's people around her or a hovering family member. That's just not the place to be assessing for violence. It's got to be done in a private or as near a private setting as the ED will allow.

You also - I think it's very important - a very simple technique that we sometimes forget is to establish eye contact and be on an equal basis such as we are now.

[Footage of Emergency Department nurse talking to a female patient]

Many of us in our roles of nurses, we walk into the room, we have our clipboards, we're standing above this patient asking questions about abuse. Especially someone like myself who's a male asking these questions, I find it very helpful - I get one of those little black stools with the wheels on it. I put it to the lowest setting where that patient is actually looking down at me. It's a very simple technique, but it's a very good way to make that patient - patient feel less anxious about being in the emergency room.

We need to be aware of indicators. And I talked about earlier the battering during pregnancy.

Major, major problem. We need to be aware that every threatened abortion, threatened

spontaneous abortion, threatened miscarriage, the

[Image: Battered Women: Indicators during child-bearing years]

potential for abuse is there. We know from the studies that have been going on that battered women are battered while pregnant and that these batterings center around the abdomen and they can lead to miscarriage.

Premature uterine contractions we need to be aware of. She's kicked or punched to that belly, that uterus is irritated, it has to contract. It has no choice. That's one of the red flags.

Sexually transmitted diseases. Especially if she keeps getting treated but her abusive partner is having multiple sex partners and he's not getting treated, she's at risk for abuse.

We know there's a connection between low birth weight and abuse during pregnancy. So if we have situations where we have women who have given birth to small babies, those are red flags.

Unexplained fetal injuries, unexplained intrauterine fetal demise, all of those are red flags.

Abruptio placentae. We - we think about that if a woman's been in a motor vehicle accident, but we wouldn't necessarily think about it if she was just beaten up by her boyfriend. Well, if he kicked her to the belly and threw her down the stairs, that's as - that's as significant as being in a motor vehicle accident.

Poor weight gain during pregnancy. Those are some of the - the pregnancy things we need to be aware of.

And then there are some very injury-specific things that we need to be aware of. And I'm kinda gonna use you as a - as a guinea pig here.

When you have accidentally hurt yourself; and all of us have, all of us have accidentally hurt - so what parts of your anatomy most often do you hurt accidentally?

[Jim McGraw] Oh, I stub my toes or I hurt my hands -

[Dan Sheridan] Okay.

[Jim McGraw] - using tools.

[Dan Sheridan] Keeping ourselves in mind as all experts on accidental trauma, because we've all been there and will be there again, we know that characteristically accidental trauma is distal trauma. It is trauma to the periphery, to the fingers, to the toes, to the knees to the bony prominences. Two parts of our head are most often accidentally traumatized. I'm six feet tall. And most architects are 5'7", so I walk into things right about here. [Indicating His Forehead] Or I bend over to pick something up and on the way up you bang the back of your head. So knowing what is characteristically accidental trauma is real important to differentiate between that and intentional injuries.

Intentionally injuries tend to be proximal, midline and, in a [making air quotes] "sick sense," sexual. Direct and intentional trauma to the face, direct and intentional trauma to the breasts, biting trauma to the nipples, direct trauma to the abdomen, direct trauma to the upper arms, to the legs, the vagina, to the vulva. It is trauma that can very often be hidden by clothing, by long hair, by makeup. So it's not trauma to the periphery for the most part. It tends to be midline.

And also an important thing with injuries - some of the forensic implications and some of the buzzwords I'd like the listeners to be aware of that are important to document, as when these cases go to court, is - one of the terms is called a "pattern of injuries." A pattern of injury most often - probably one of the frequent examples given is you have a young baby with multiple rib fractures in various stages of healing. We know that that's child abuse. That various stages of healing gives you this time perspective. So a pattern of injuries are injuries inflicted over time. Now that's different than a very similar sounding term called "patterned injuries." A patterned injury is where I have reasonable cause or I have reasonable certainty what object caused that injury. And there are many injuries where we can be pretty sure what object caused that injury, it's patterned. Okay? So those are two forensic buzzwords that - that criminal prosecutors love to see and forensic experts love to see in nursing documentation, if we have that certainly as to the object.

Also, another one of the red flags is -- are treatment delays. We know that battered women and elder abuse survivors frequently try to [making air quotes] "nurse" themselves at home, or the abuser doesn't allow them to come in for treatment. And it's only after several days of not getting better that the abuser will allow them in. Or maybe they have to wait for the abuser to go out of town on a business trip. And - and so the abuser will kind of come in at that point.

In a few minutes, or in a minute or two here we're going to go to some slides that I have taken over the years of elder abuse survivors and battered women that I have worked with in a couple of different clinical settings. All of these women who I have photographed have signed consent, not only for the photos to be taken, but the slides to be used as teaching slides.

And one of the things I think that's important to let audiences know is that by statistics alone there are women in the audience right now, in the television audience, who have been or are in abusive relationships, or someone very close to them is in an abusive relationship. And seeing these slides may bring back some painful memories. And I guess I just wanna say it's okay for those women who are in the audience to not look at these slides if that's more comfortable. But I think they can be very instructional as to the type of injuries that we were just describing. So maybe at this point we can go to the first slide.

[Footage of a woman's back]

Okay. What I wanna point out to you is if you look at the upper right shoulder, Jim, can you describe that for me?

[Jim McGraw] Oh, it's almost a comet-shaped linear mark. I'm not sure what it is.

[Dan Sheridan] Okay. You would probably document that as a looped patterned injury. I'm pretty clear as to what caused that. And also her history confirms that. That's a looped pattern injury from being whipped with an electrical cord, an extension cord. Some people might guess that that is a coat hanger, but a coat hanger would give you more of a rectangular impression, thinner than that. So that's a looped cord.

And now if you look at the upper right shoulder and you look at her mid-back to the right side, you'll see that particular wound is scabbed over. And then right above that you have some vertical linear scars that are well healed. So now what you have is a woman who has a pattern of patterned injuries. Okay? So she has had injuries inflicted over time. So if she were to say to you

this is the first time her husband's ever beaten her, you have some clinical evidence to confront her in a positive way that these beatings have been occurring more than once.

Now I want to refer you to her left lower back. You see that sort of patterned bruise there? Now, what caused that?

[Jim McGraw] I don't know. Some sort of object.

[Dan Sheridan] All right. So that is - some people guess iron, but that's actually the heel of a man's shoe. So when you look at that area, she - after she was down, she had a kick injury to the back. She also had one up higher on her left shoulder. So these are patterned injuries. Now obviously to cause that impression on the back, we as emergency room nurses have to be very much concerned about internal injuries.

Now we're gonna be seeing in the next slide some additional patterned injuries.

[Image of a woman's abdomen]

These are typical patterned circular punch injuries, and this woman was punched multiple times. She came in with a chief complaint of shortness of breath. Well, that makes sense. Most of those injuries are by her floating ribs. And obviously if you were nailed there, it would be hard - hard to breathe. Now again, if we don't slide up her gown and give her a thorough exam, we might miss those. We might thoroughly auscultate her back, but we might miss those injuries.

And on the next slide we're going to see neck injuries.

[Image of a woman's neck]

Neck are very common. Battered women are choked a lot. And you can see neck injuries that can be hidden by hair, as we have in this slide.

And on the next slide

[Image of another woman's neck]

you're going to see the neck - neck injuries can be so low that a woman can just wear a regular blouse or sweater and no one would know that those neck injuries are there.

On the next slide we'll see a couple of important things forensically.

[Image of another woman's neck]

First of all, this woman was choked, and you can see the finger patterns, whereas she was being choked, she turned her head and you have that abrasion in the area. So you can see at least two fingers there.

The other important thing to note is that in this slide there is something called a standard. A standard is where there is no doubt. I put a ruler in there. It's actually called a gray ruler which developed - film developing people, they focus on that gray and it gets more true colors. But that's important because no defense attorney could ever say that I used a zoom lens to make something look bigger than it really was. There's a standard in there.

Now in the absence of a ruler good common everyday standards that are available are nickels, dimes, quarters, something that you can put into the picture that gives a sense of size.

[Image of another woman's neck]

Now in the next slide this woman was choked with a wide rope, and you get that wide pattern as she fought the rope. So neck injuries are probably among the most common that I see.

[Image of a woman's upper arm]

On the next slide we're going to see the - a series of the most common injuries that I see in my role, and those are punch injuries to the upper arm. This you can see the patterned circular punch injuries. This woman was hit at least twice to that arm. And on the next slide, please

[Image of another woman's upper arm]

we're going to see more. She was hit multiple times. And what you'll notice on these slides is most of these slides are of the left arm. And I see battered women frequently having punch injuries to their left arms, as we'll see on the next slide.

[Image of woman's upper arm]

I believe that's also - okay. That might be a right arm. But left arm injuries are real common. Give me a guess why?

[Jim McGraw] Well, if I'm right handed like most people and I strike you, I'm more likely to strike you on the left side.

[Dan Sheridan] And that is part of the reason. But you also have to put into the context of where a lot of the arm injuries occur, and they occur in the automobile while he's driving. She's a passenger. They're arguing. He's saying shut up. He reaches over with his right arm and he's punching her to the left arm.

Now I gave a similar lecture on this in England, and - and lo and behold, they were describing all of these bruises to her right arm. And that makes sense obviously when they reversed the steering wheel. He's just reaching out with his left arm and hitting her to there.

So on the next slide

[Image of woman's upper arm]

what we'll see is - also you'll see different ages. Obviously this is not a fresh bruise. But I want to caution nurses not to try to too tightly date a wound, because people heal at different rates. So if we were to say, you know, a circular punch-like injury approximately 7 to 10 days old or approximately 14 - try to avoid that, because if she has a difference in healing time secondary to medications that she's on or for a variety of reasons, if we date it and then they have a suspect in custody and it's - he wasn't in town during that window of time, he may walk free even though he's the one who did that bruise. So try not to too - try to date things exactly. That's a very difficult science, dating injuries.

[Image of a woman's leg]

On the next slide what we'll see - and this is an elder - elder abuse survivor that I worked with. And what you'll see all over her knees and her legs are fingertip injuries. This is a woman who really wasn't being beaten per se. She had lived with her brother her whole life. He was elderly. She at this point had profound Alzheimer's Disease. She was incontinent. And this is a woman - he was so frustrated in caring for her that every time she'd become incontinent, he was just there and the minute she'd finish, he's like grabbing her and jerking her back and forth. She was perfectly clean. She had no decubiti. But his roughness in handling her - but - but it's an example of these - these fingertip-like injuries all over her.

[Image of a woman's leg]

On the next slide what you'll see is women are frequently kicked and hit to the upper legs. And again arm injuries and leg injuries can be hidden year 'round by skirts, dresses, shorts. There may be people sitting next to you that have injuries that are being able to be hid by clothes, but underneath the surface you can have some pretty significant injuries.

[Image of a woman's legs]

The next slide has some very classic forensic implications. The injury to her right medial thigh is considered a forensic classic. It is a punch injury and the person who punched her was wearing a raised ring, most likely not a wedding band. A raised ring where you then end up with a U or a horseshoe-shaped abrasion in the middle of the wound, the middle of the bruise. What you also notice on her knees are fingertip injuries. This is a woman who I worked with whose husband

wanted to have sex. She said no. He said yes. She said no. He beat her. And you can see as he raped her and pulled her legs apart, that's where she got the fingertip injuries.

[Image of a woman's face]

The next slide shows a different woman, a different abuser. Right there in the middle of her forehead you'll see that you U or that horseshoe-shaped abrasion. Again, you knew - you know right away that that is a punch injury. Look at her eye. Eye injuries are real common. Blowout fractures are real common. Nasal fractures are all real common in - in abusive situations.

[Image of a woman's hand]

On the next slide we'll see this - this makes sense. If someone's coming at you with a knife, what are you going to do? You're going to put your hand up in a defensive posturing position, and as a result her injury was right to the palm of her hand. Defensive posturing injuries are real common. In one of the opening scenes for this show they showed a man sort of pushing and shoving a woman and her arms were up in a defensive posturing mode. And if you look at the next slide

[Image of a woman's lower arm]

you'll see that the - very frequently you're going to get these mid-ulna abrasions, these mid-ulna bruises. And if this woman said she fell, look at her palm. What's her palm look like? Think of ourselves. We've all fallen down. And what do we do when we fall? What's the very first thing we do? We put our hands out to put the brakes on. She has no abrasions to her hand. She was non-tender there. And if she said she fell, it just doesn't make sense. But obviously she's - was hit at least twice to the mid-ulna.

[Image of a woman's lower arm]

On the next slide you can see that this woman was not only hit to the arm, but if you look carefully, there's almost a linear sliding motion to that where you can actually see as she was hit, it slid down. Now obviously this woman's injuries also required the paramedics to put a C collar on her, and that's one of the things we have to remember, that battered women can often be multi-system trauma patients.

[Image of a woman's lower arm]

On the next slide again, these are among the most frequent that I have, defensive posturing. She has multiple bruises on her arm. So her abuser was trying to hit her multiple times as she tried to defend herself.

[Image of a woman's arm in a cast]

The next slide, one of the rare times you'll have a mid-ulna fracture in the absence of radial involvement is in abuse situations. If you think of when you fall, and if any bone's gonna break first, the radius absorbs 90 percent of the impact. Now her radius is fine, but she's got a mid-ulna fracture. That's a defensive posturing move.

I also want to point out on that last slide did she look healthy?

[Jim McGraw] No, she didn't look healthy at all.

[Dan Sheridan] She looked very emaciated. And we'll talk about that in a few minutes.

The next slide - I believe we have more.

[Image of a woman's lower arm and hand]

Yes. This is an elderly woman who was being cared for in her home by her adult children who they weren't really abusing her. They were spanking her when she was naughty, when she was bad, when she would be incontinent. And what you'll see to her hand and also to the anterior surface of her arm is where they were sort of slapping her in spanking motions.

They weren't intentionally abusing her; at least in their minds they weren't. But they were spanking her to try to get her to do things they wanted her to do, very similar to treating - when that elderly person begins to be treated very much like a child. And in this home they were spanking their elderly child. Again, not appropriate, but again the elder abuse can come in many different forms with - ranging from malice to not malice, to ignorance, so.

[Image of a woman's face]

So, on the next slide this is a classic patterned punch injury with him wearing a ring that then took off several layers of her skin. She needed plastic surgery to re-approximate - re-approximate her lip.

[Image of a woman's face]

On the next slide this is a woman who received a blowout fracture. So eye injuries can be extremely, extremely common and blowout fractures can be very common from being punched to the eye. And if she says she fell down and landed on her face, it - it just doesn't make sense. Okay?

[Image of a woman's face]

On the next slide what we have is what we think is the typical battered women. Ya know, she's got bilateral periorbital ecchymosis. Translated is she has black eyes. Well, abusers tend not to hit their victims or their - their - their "loved ones;" and I put that in quotes -- to the face unless they want to more isolate her from the rest of society. This woman was going to start a new job. He did not want her to work. So he proceeded to hit her to the face. She called up her employer-to-be and said thanks, but no thanks. I found another job. She really hadn't, but she wasn't going to go to work the first day on the job looking like this.

[Image of a woman's face]

On the next slide this is a woman whose first husband never abused her. He died. This was her first attempt at dating. Now, she was about 60 years old, so was this elder abuse or is this spousal abuse? Her first attempt at dating in later years she was beat up by her abuser.

[Image of another woman's face]

Next slide. This woman came in positive loss of consciousness and she kept screaming fix my face, fix my face. My boyfriend beat me up. Fix my face.

The paramedics walked her in, not where I'm currently working, at a former institution. Walked her in, even though she had a positive loss of consciousness at the scene. Now if she was in a motor vehicle accident, hit the steering wheel, positive loss of consciousness with a split forehead, she would have been presented on back board, spine precaution, sand bags. She would be taped down. She would have been rule out multi-system trauma. This is the same woman who - the very first slide with the pattern of pattern injuries.

[Jim McGraw] Um-hum.

[Dan Sheridan] This is the same woman who had the big kick mark to the leg. This is the same woman who had multiple other injuries that we haven't shown. No one even looked at those until we got her to the ER and I suggested we rule out multi-system trauma.

Now this is also a woman whom they refused to admit. The doctors would not admit her.

Nothing was broken. They said we don't do social admissions. If she was in a motor vehicle accident with a positive loss of consciousness, she would have a 24-hour rule out closed head injury admission, but because this was a domestic and she had a little alcohol on her breath, and she had no insurance, all of those factors sort of led into the fact that she wasn't initially going to be admitted. Advocacy on the part of ED nursing got her a 24-hour admit.

[Image of another woman's face]

The next slide this woman was walked in by the paramedics, positive loss of consciousness. She was temporarily blind. Her eyes were so swollen, she couldn't see out of them. She also had some fractured teeth. And look at the dissymmetry in her jaw. We thought for sure she had a jaw fracture. And she did, from six months ago that she never sought treatment for. And that's how her jaw healed together.

Surprisingly she was able to chew pretty well. They also we're going to send this woman home -- positive loss of consciousness. They were going to send her out back to her abuser blind. Now again, nursing advocacy got her a 24-hour admission. Her swelling went down. This woman went directly from the hospital into a battered women's shelter.

[Image of another woman's face]

On the next slide this was an old woman who was brought in by her husband. He said she fell down. And of course one of the myths that we have is that old people fall. And they do, but sometimes they're also pushed.

If you look closely at her neck, she was choked by her husband, was punched to the eye and then she fell and that's how she got the big goose egg on her head. Initially she couldn't tell us this because she didn't have her teeth with her and we couldn't understand her too well. A few days later her niece brought her teeth in. We could understand her just fine. So this was a battered woman grown older. But we assumed old people just fall. No, they're don't. They're also pushed and intentionally hurt.

[Image of another woman's face]

On the next slide we have a woman who her husband and she were on their anniversary and they both were drinking and during the argument that ensued he put the .22 right up to her skin and pulled the trigger. And you see the bone mark and also the bullet fragments all in her orbit area. Now, these are one of the battered women who really is a challenge to the nursing and to the law enforcement profession because she's very upset that her husband was charged with attempted murder, was very upset that he's still in jail, and because he really didn't mean to shoot her to the face. And these can be very difficult cases to work with, but we still need to do the good documentation and provide her with those options.

And I don't know if we - yeah, I think that's the last slide that we have.

[Jim McGraw] Well, you've talked a lot about physical signs and symptoms of - of abuse ranging from the patterns of injuries as well as patterned injury. Are there non-trauma things, behavioral things -

[Dan Sheridan] Yes.

[Jim McGraw] - you could be watching for?

[Dan Sheridan] Yes. First of all, I'm going to start out with behaviors that might be red flags that the spouse or the partner or the caretaker that's with the patient might be an abuser.

If that partner or that caretaker is - is unwilling to leave the patient's side. And - and I use the word "hovering." And I want to use myself as an example. I'm a nurse and of course when my family members are sick and ill, and you know, I want to be there with them, I hope I don't come across as hovering. I hope I come across as concerned. I hope if they ask me to step outside, I would say, okay, that's fine. But when you have the abuser who brings the patient in, whether it's elder abuse or domestic violence, they tend to hover and they will not leave that patient's side. It's very difficult to get them to leave.

Or you - you're the patient and I ask you something and this other person answers for you, that's a red flag that abuse is going on.

[Text on screen] Abusive Partner/Caretake Behavior: Partner/caretaker unwilling to leave survivor's side, Partner/caretaker speaks for the survivor/belittles what is said, Partner/caretaker makes derogatory comments about the survivor's appearance/behavior

Or right there you may say something to me as the patient and the abuser is belittling what you're saying right there in front of us. Big red flag.

When I say "over-solicitous with care providers," I kind of call that that instant male bonding stuff. I tend to see that a lot as a man working in this line. Where here is a guy that I've never met before and he's either abused his wife or maybe it's a son who's abused his father, and all of a sudden he's talking to me like we've been buddies for 20 years. It's just sort of that - try that instant bonding stuff. For me that's a red flag that there may be abuse going on.

Or that caretaker is totally emotionally absent and out of tune with what's going on with the patient. It might be an elder abuse survivor who's in tremendous pain and - and the person that brought them in says, well, did you pull anything out of the freezer for dinner? I mean, they're just not in touch with what's going on with that patient.

[Text on screen] Abusive Partner/Caretake Behavior: Partner/caretaker is oversolicitous with care providers, Partner/caretaker is emotionally absent or out of tune with the survivor

We need to be very much aware of the overlap between alcohol and drug abuse and family violence. There are no studies that definitively show that alcohol and drugs cause the violence. What we tend to believe now is that alcohol and drugs are a risk factor and an excuse for violence.

There are two separate problems: If there is alcohol use and abuse going on, if there is drug use going on, that family is at higher risk that abuse is going to occur. That's true. No matter what socioeconomic level you're at, you're at a higher risk. But fixing the alcoholism, fixing the drug problem, doesn't fix the abuse. They're separate issues.

[Jim McGraw] Are there non-physical signs and symptoms of abuse?

[Dan Sheridan] Yes. If the patient needs to ask permission of their caretaker, that's a big thing.

[Text on screen] Non-Physical Signs and Symptoms of Abuse: Late prenatal care, Missed appointments (canceled by a male), Survivor is obviously afraid of partner/caretaker, Survivor has need to "ask permission" of partner/caretaker

Missed appointments. Depression is probably the biggest symptom. Any patient with depression needs to be assessed for violence. Suicide attempts, real common. We talked about those earlier. Anxiety disorders. If the patient turns to alcohol or drugs, that might be their way to cope with abuse.

That very emaciated woman, she had an eating disorder. She saw herself as fat. Her abuser kept calling her a fat slob. No one will love you but me. She saw herself as fat. She had an eating disorder. Sleep disorders, real common with elder abuse and battered women, but we never assess for sleep disorders.

GI disorders, real common. Migraines, real common. Post-traumatic stress disorder, real common for people who are in chronic abusive relationships.

[Jim McGraw] So how do we approach this topic? We've got a patient in the ED, perhaps a physical sign or two, perhaps a behavioral sign or two. How do we actually ask the question and get effective answers?

[Dan Sheridan] I think if you've never asked the question about abuse, it can be a very uncomfortable question to ask. And I'm going to share with you a very personal experience. When I was a junior nursing student -- I won't tell you how many years ago. And I was in my OB/GYN rotation and I had to go in and for the first time in my life ask a woman, a young

woman about a history of vaginal discharge. I was very uncomfortable. And my faculty instructor said, Dan, you can do this. Go on in and ask. And I did. And lo and behold, I heard more about vaginal discharge than I ever wanted to know about. It wasn't the patient's uncomfortableness. It was mine.

Now at this point in my career, as nurses, we can ask people just about anything we want. If the nurse has never asked about abuse, it could be uncomfortable, but once you ask, that patient might tell that nurse more about abuse than that nurse ever really wanted to know about.

Routine assessment is the best way to do it. For example, there are some routine assessment questions, and that's one of the handouts in the back that's both in English and Spanish that people can refer to later.

But for example, a routine question - and I'm going to use you as if I'm asking the question. Do you feel emotionally abused by your partner or your caretaker? Has your partner or caretaker ever hit or slapped or kicked or otherwise physically hurt you? Asking these very direct questions is one of the best ways to get these answers.

Are you afraid of your partner or your caretaker? Maybe that abuser's never hit them, but maybe put their fist through the wall. Maybe they didn't have to hit them. They're afraid.

Do you feel that your partner or caretaker tries to control you? Again, we talk about this domestic family violence as a control issue. We need to ask about it.

Has your partner or caretaker ever forced you into sex when you did not wish to participate?

And that is one of the nicer ways to ask. If you ask a wife has your husband ever raped you?

Even though most states have marital rape laws, most wives don't even - wouldn't even think that that's possible.

Or if you ask the battered woman has your boyfriend ever sexually assaulted you, it's just not - they don't view it in those terms. But they will view it in has - has someone ever forced you when you didn't want to participate?

Now, those are routine screening questions. And the best way to assess for family violence is to routinely ask every patient those questions, the same that we ask about allergies, what surgeries have you had, what medications have you had. When we think of the millions of Americans who are abused annually, we need to begin asking these routinely.

Now you can ask some very injury-specific questions. Let's say you're my patient. And you've got a bruise or a black eye, or you've got an injury that - that doesn't look accidental. I can say to you the injuries that you have look like they may have been caused someone. Has anyone hurt you?

Or if you come in with a psychological symptom, you're depressed, you're anxious, maybe you're suicidal, I'll reflect back whatever it is that you're in with and I'll say it's common when people are depressed such you as you are today and - and wanting to hurt themselves as - as you've tried today that there may be abuse in the home. Is that happening to you? A very effective way and frequently they'll say yes if it's there. Or they're non-verbals might give you a clue. Even if they say no, they're non-verbals might be screaming yes.

After you've established that there is abuse going on, you need to at some point ask about that physical/sexual abuse link. As we said, about half of the battered women who are out there are being sexually abused. We don't know how many elder abuse people are being sexually abused, but we know that there are many. But one of the last questions that I ask is -- and I'll make a statement like that -- is that we know that when women such as yourself are being physically abused no may not mean no. You may be forced to participate in sex when you didn't want to participate. Is that happening to you? Kind of keep it open and in general.

Frequently it's at this point, whether it's with the elder abuse survivor or the battered woman, that I see the tears for the first time in the patients that I work with. It's this question right here that really then triggers the affect and the pain that they're experiencing.

They're pretty much able to be stoic and kind of tough it out on the abuse questions, but it's usually when they say yes to this one, that's when it's emotionally difficult and you really have to be working with the patient with the emotions.

If you have a positive history of abuse, one of the handouts in the back is the danger assessment instrument by Jackie Campbell that I find very effective. And it's both in English and Spanish.

That the more someone would score yes on that assessment form -- it's 14 questions -- the greater the likelihood we believe that she is going to end up dead because of the abuse. So I think if possible if you can do the danger assessment, that's a real helpful tool.

[Jim McGraw] Well, after gathering all this assessment data the nurse is faced with that terrible task of the pen and the blank piece of paper. Where do we go from here?

[Narrator] I'm going to share with you one of my pet peeves when I read ER documentation, probably one that I was guilty of myself many years ago, is that you'll have a patient who comes to the ER who tells you exactly what happened. Who beat them, what happened. You get the really detailed history. And you read in the medical record patient states she was beat by known assailant. Patient states she was beat by boyfriend. Well, that from a forensic point of view is worthless documentation.

What forensic medical and legal experts want to be charted is, for example, patient states that her husband Jimmy Jones beat her last night at 3:00 a.m. at the corner of 4th and Main witnessed by her Aunt Mary. I mean, get it in as much detail. That's what the patient's telling you.

I don't really care if you use the SOAP format. Most of us were taught this SOAP format in school: subjective, objective, assessment and plan.

And other than when I use it in - with the domestic violence and family violence patients I work with, I tend not to use it too much once I'm out of school.

But whether you use a SOAP format or a narrative progress note, if you write patient states her husband, Dan Sheridan, beat her, I can't sue that nurse. That's the patient's statement. That's - I can't sue the nurse for writing that. And I even write patient states her husband Dan Sheridan, Social Security number 318-48 - date of birth - I put all that stuff in there, because that is real important, for example, if you're security department at the hospital is able to do a back - get into the computer -- the police computers to find out if he has outstanding wants and warrants on him. That's important stuff to have.

So I think you need to document as close as possible her history of abuse and as close as possible to her words. Then you need to document objectively what you're seeing. What can get nurses in trouble under the assessment part is if you write patient's husband or boyfriend is a wife abuser. Patient's son is abusing - is an elder abuse perpetrator. Now you've made a statement that can get you in trouble. So I think you need to avoid those.

I write per history patient's involved in an abusive relationship with her son, with her husband, with her daughter, with his daughter, with his son. So I'll just - you know, I'll reflect per history patient's involved in a abusive relationship.

You need to try to avoid using the word "refused" when you document. A lot of times I'll see in the medical records patient refused to make a police report. That's a very victim-blaming statement. I have the right as a patient to choose to do whatever I want. And if I choose not to have my appendix out, don't write I refused to have my appendix out. I chose not to.

Now, I may pay some consequences for that. I prefer to write patient chose not to talk to the police. Patient chose not to call the shelter. Patient chose not to call the hotline versus that word "refused."

Plus I think it's important that when we document that we document accurately. And one of the things - the examples I use is - is a - a blatant mistake I made early in my career. Earlier we saw a slide of a woman who had put her hand up in a defensive posturing motion and she was cut on the hand by a sharp object. I wrote in the medical record patient has approximately four-inch laceration to the palm of her hand.

[Image of woman's hand just mentioned]

Well, the defense attorneys tore me up inside - just tore me up in court because by definition a laceration is a splitting of skin from blunt impact. And I - that's not a split. That's a cut. So everything that I testified to after that point was subject to criticism and there was that reasonable doubt and an abuser walked free in a large part because I documented inaccurately.

[Jim McGraw] Is - is this the slide you were referring to?

[Dan Sheridan] That is the slide, yes. I -

[Jim McGraw] And you called that a laceration?

[Dan Sheridan] I called that a laceration, and that is not. That is a cut. It's a sharp wound. Either of those are fine. A cut or sharp wound to the palm of her hand is - is - is more accurate than saying a laceration because by definition that's not a laceration. That's not a splitting of the skin. That's a cutting of the skin.

[Jim McGraw] I see that the handout talks about forensic implications. I'm not quite sure what you mean by that.

[Dan Sheridan] Everything you write or don't write has forensic implications in these domestic violence/family violence cases. Since it is a crime in every state the likelihood that this document could be subpoenaed is - is very - is very good.

What I tend to get subpoenaed on more often is not so much my - my documentation, but my photographs. I strongly encourage all the patients I work with to consent to be photographed. Not - not all of them do agree. Some agree to be photographed, but not to be used for teaching, but [List of requirements for documentation continued.]

- but they can use them for police.

So the court cases usually occur, oh, God, months after the actual abuse. Those photos can have tremendous forensic impact when shown to a jury or a judge. So I think we need to remember that we need to document - that that case could very well end up in court. More and more though the courts are not subpoenaing the nurse or the physician to testify. They're just using the medical record as evidence in and of itself.

So if people are afraid to document because they don't want to go to court, more and more courts are not calling in the nurse. They may call in someone like myself who's a - more of an expert in this area, but most often they're not called in. But it has forensic implications. And use photos. If you don't have photos, at least use an injury map. Make some sort of pictorial documentation of what you're seeing right at that point in time in the emergency room.

[Jim McGraw] Thank you, Dan. I'd like to remind our callers that in about 20 minutes we - we'll have the opportunity for - actually more recently than 20 minutes. In about 10 minutes or 15 minutes we will have the opportunity for you to call in your questions to the number you see on the screen and we'll direct the questions to Dan and see if he can help you better understand this topic.

Dan, we've done our assessment. We've screened the patient appropriately. We've gotten her physical injuries cared for. We've documented. But I presume these people have continuing emotional needs -

[Dan Sheridan] Very much so.

[Jim McGraw] - that we need to, to the degree we can, support and help them with while they're in the ED. What is it they're looking for from us?

[Dan Sheridan] Okay. I'm in the process of - even though I swore I'd never go back to school, I'm in the process of completing a Ph.D. in nursing. And part of what I'm doing in that Ph.D. is I went out and I interviewed a whole bunch of family - adult family violence survivors --- battered women, elder abuse. And I said what was it that you found helpful or would have found helpful from your health provider, from your nurse? What was it that we could have said or did say to you that made a difference?

And there were some very - I was shocked to find there are some very simple things that women remembered that helped plant the seed that allowed them to eventually break out of these cycles of violence. And one of the very first things that these women were telling me is that they want us as nurses to say I believe what you're telling me. I believe what you're telling me. Because the abuser has said if you tell anybody, they're going to think that you're crazy. No one's going to believe you. So say to that woman you're not crazy. I believe what you're telling me.

Not only that. Tell her that no one deserves to be beaten. Whether it's an elderly person or a battered woman, just say no one deserves to be beaten, I believe what you're telling me, and you're not crazy. Now that took probably less than 10 seconds. Pretty important stuff though. That's what patients are remembering. You need to be able to say to these patients that they're not alone, that this is happening to lots of people. We talked earlier that in family violence homes isolation is pretty normal. These folks feel very isolated from family, from friends, from the community, from help. So let them know that - you can say for example, you know, we see a lot of elderly people who are being abused, or we know that abuse occurs to a lot of elderly people. We know that a lot of women are being beaten. When you make that sort of statement, what you're saying to that person is you're not alone and it's okay for you to talk to us about it.

You need to let them know that it's a crime. They may not want to do anything at that point in time, but they need to hear me say to them, or you say to them, or the nurse say to them no one had the right to do this. It was a crime. It was a crime when they hit you. It was a crime when they kicked you. And you have the right to choose to follow through with criminal prosecution. So they need to hear that. They need to - you need to try to instill a little bit of hope. And you don't want to say, oh, you know, you can get out. It's easy. It's not easy. It's very difficult.

But what you can say is with help and support you can and women are able to get out of abusive relationships. And in a few minutes we'll talk about some safety plans.

Let her know that that cycle of violence can be broken and where she can go for help. When I first created this program - a program in Chicago, a family violence intervention program, we printed up thousands of these wonderful looking brochures.

This was back in '86. I still think they're sitting in boxes somewhere collecting dust. And at first we couldn't figure out why aren't women taking these brochures home? Well, the light bulb goes off. If she's in an abusive relationship and she takes this big brochure home and he finds it, she's dead meat.

So then we said, okay, we've got to come up with something a little bit better. So we came up with wallet-size referral cards. And actually shelters had been using these for years. But we have these available and these are -

[Jim McGraw] Hold it up so we can all see it.

[Close up of card with a list of numbers]

[Dan Sheridan] They're just business cards that are folded in half. And inside are hotline numbers, elder abuse hotline numbers, child abuse hotline numbers, battered women shelter numbers, phone numbers to the local court systems if she wants information on restraining orders or protective orders.

There are neighboring county shelter numbers on here. It's - it's pretty common that a woman often has to leave her county in order to be really safe from her abuser, especially if he is a police officer in that county or he works for the phone company. People who work for the phone company sometimes can - I mean, if there - if there are safety reasons that she needs to leave the county, we have the 24-hour numbers on here.

So we make these cards available in the emergency room. We - actually up on our mother/baby unit at the hospital I'm at in Oregon we have these in every single woman's bathroom up on the mother/baby unit. It's one of the few places a woman can go for a few minutes of peace and quiet. And she goes in there. And these cards disappear as fast as the nurses can restock them. So having wallet-size referral cards is an effective way to get the information. She can hide these. She can slide them under, you know, a sleeve and she can put them in her sock and - and she can - she'll use these cards when they're ready. Plus it's an effective way when Joint Commission comes for your site visit, you can show them that you've printed up wallet-size referral cards. So they can serve multiple purposes.

On the intervention, in addition to the wallet-size cards,

[Text on screen] Dan Sheridan, RN MS

more and more hospitals are looking at creating hospital-based programs. And that's one thing I've been able to do twice now in my career, once in Chicago and now in Oregon, where I get paid to do nothing but family violence interventions.

And I think in your larger hospitals there's a trend for people to begin to explore looking at that more often. At this point there's only about 10 in the nation. And in the bibliography in the back there's referral for an article that I wrote on how to create hospital-based programs, and people might want to look that up if they're interested in doing that.

But it's an effective way. It must be interdisciplinary. This is not a problem that needs to be turfed to the social worker. Its not a problem to be turfed to the psychiatrist. It is a problem that all people involved need to be able to do their role in order to effectively break the cycle of violence. So it's not just a - one of the problems for someone else to take care of. We all need to do our - our part of documenting.

Crisis intervention is a big part of what I do. Creating safety plans is a big part of what I do.

[Jim McGraw] What's a safety plan?

[Dan Sheridan] For a variety of reasons many adult family violence survivors are going to choose to return to that abusive home after being treated in an emergency room. One of the reasons they're returning is because probably 9 out of 10 women who call shelters around this country tonight who are eligible for shelter are turned away for lack of shelter beds.

So if we naïvely say to a patient why don't you just go to a shelter, what we've done is has not been very helpful because the reality is that shelter's probably full. And maybe that patient can get on a waiting list, or maybe there'll be an opening three days from now, but many times the patient has no choice but to go back to the abusive home and try to keep things cool until they're able to get into shelter or find an alternate place to go. Or she may choose to go back because he's sorry and she wants to give him one more chance. So then I get into some survival of safety

planning. For example, I tell almost every woman who's returning to go ahead and pre-pack an emergency bag, an emergency flight back, because invariably if she does decide to leave two weeks later, it's going to be 2:00 in the morning.

And instead of just leaving with the clothes on her back, in this bag I say put several changes of underwear. Put your important paperwork in there. If you're going to leave with your kids, put their birth certificates in there, their shot records. If you've got a child in diapers, put a handful of diapers in there.

If she's a smoker, I don't give her the lecture at that point about quitting smoking. I tell her to put three packs of cigarettes in that bag, because if she leaves at 3:00 in the morning, she's going to be chain smoking. Put a roll of quarters in there because she's going to be using pay phones seeking help.

If she's not able to keep the bag at home, can she keep it at a friend's house, at a neighbor's house? If she's working, can she keep it at work? So that's one of the safety plans that I talk about.

Another safety plan is how to access quicker 9-1-1 response. Now, I never want to coach a woman to lie to 9-1-1, but if she calls 9-1-1 and she says my husband's beating me or my boyfriend's beating me, or if it's an elderly person and the elderly person says my son's beating me, my daughter's beating me, that goes over the police air waves as a domestic in progress and the police will respond and they are responding quicker. But if she says to 9-1-1 there's a man here beating me, that goes over as an assault, a battery in progress and the police are going to be coming probably quicker.

The police still, even though they're getting better trained, probably would prefer to answer dog barking calls than domestics, even - and that might get me in trouble with police officers out there, but it is not one of their priority cases, even though they're getting better trained. But by saying there's a man here hurting me, it may shave two or three or five minutes off response time, and that is a lot of time if you're being beaten.

I also teach women where they can go for emergency help 24 hours a day, 7 days a week, 365 days a year and that's to emergency rooms. Not necessarily to be a patient -- and this might get me in trouble with ER nurses -- but I've, on more than one occasion my beeper's gone off at 3:00 in the morning and it's my emergency room and they say, Dan, there - there's a patient here who doesn't want to be seen, but she's here with her three kids and she said that you said it was okay for her to come to the ER. And I said that's right, because I don't want her wandering the street at 3:00 in the morning with her kids where she could be victimized by someone else on the street. Put her in the ER, give her a cup of coffee, give her a blanket, and either get the nurse clinical specialist or get your social worker on call involved. She - she's - at least she's in a safe environment and she has gotten through that night.

Frequently when people leave in the middle of the night they're back by 6:00 in the morning because it's - they just don't want to be wandering the street. So at least we've given her a safe place to go.

So those safety plans and each safety plan could be unique. The best people to teach safety plans are your local shelters. Frequently I - if I'm running a blank on how to come up with a safety plan, I'll just call the local shelters and we'll strategize together. The woman's on one extension, I'm on the other, the shelter worker's on the other and we'll come up jointly with safety plans of where she might be able to go temporarily in order to stay safe.

Some hospitals have a limited supply of hotel vouchers. Well, if she's been battered and maybe we can get her into a hotel for a night or two. Not all hospitals have them, but some hospitals do.

So there are - there are some ways we can get creative that buys her some time until she can access resources. So safety plans can be real important.

Knowing your local resources. I spend a considerable amount of my time building those bridges between the hospital and the community-based programs so that when they call me or I call them, we're often on a first name basis and it really does facilitate that interdisciplinary networking.

[Jim McGraw] Well, Dan, you ready for some phone calls?

[Dan Sheridan] I'm ready.

[Jim McGraw] Well, let's see. Let's take your phone calls. The number on your screen on - is the one to call. And in the interim while we're waiting for calls, some thoughts of - oh, I know. Dan, you wanted to share with the audience organizations that they could affiliate with -

[Dan Sheridan] Yes.

[Jim McGraw] - if they are interested in domestic violence and then I cut you off. I'm sorry.

[Dan Sheridan] That's right. There are two national nursing organizations that coming together who are working with domestic violence issues, and I'm very involved in - in both. So if folks are interested, there is a Nursing Network on Violence Against Women International.

[Text on screen] Nursing Network on Violence Against Women International and/or Int. Association of Forensic Nurses

Dan Sheridan, MS, RN c/o NNVAWI Trauma Program, UHN 66, Oregon Health Sciences University, 3181 S. W. Sam Jackson Park Road Portland, OR 97201

And I believe there might be an application form for that in the packet.

There's also a new and growing organization called the International Association of Forensic Nurses. And they have a subcommittee on domestic violence. So both of those organizations -- and many of the members belong to both -- are looking at ways on how to improve nursing response to domestic and family violence. So if anybody's interested, feel free. The address is probably on the screen or will be on the screen. They can write to me and I can send them information on both of those organizations.

[Jim McGraw] Well, thank you, Dan. I'm told we have a call. Go ahead, ma'am or sir.

Oh, I'm sorry. One of the things that dawned on me while you were talking, Dan, was, to be frank, you're a man. And I wonder is being a man an obstacle to doing this job well?

[Dan Sheridan] I have not found it to be an obstacle. I say, and I actually do mean this, that family violence survivors, battered women, elder abuse survivors, are literally dying to tell their story to someone. And whether you're a male or a female has really not been the issue. I think the issue is if you are able to demonstrate to that patient that you're empathic, that you're able to listen to what they're saying, that you're taking them seriously, that is more important than your gender.

So I have not found it to be an issue at all in - I've been working with survivors of family violence as a volunteer since 1978 and getting paid to do it since about 1986 and I have not found it to be a significant problem.

[Jim McGraw] The ED nurses today are faced with a tremendous variety of demands on their time and what you've described is a process for assessing patients that unfortunately, as good as it is, requires time.

[Dan Sheridan] Yes, it does.

[Jim McGraw] Being an ED nurse yourself do you have any ideas that you can share with people about how to find the time to do what's necessary to find these people?

[Dan Sheridan] I think part - at times I think part of the uncomfortableness - and I don't want to use the word reluctance, but uncomfortableness that I've seen emergency nurses have around assessing this is that it deals - I think part of our training as nurses. We're trained that we have to find this time to do these one-to-one, face-to-face in-depth psycho-social assessments. And that's not very practical when you're working a busy ER on a Saturday night and all hell's broken loose and - and you've got all these patients and - and you can do your assessment in bits and pieces. Battered women and elder abuse survivors have been accommodating their abusers for a long time. They'll be very patient with you. If you say to them I'm very glad - you've asked your questions and they said yes. And just say I'm very glad you've begun to share with me about this, but I need to share with you. I need to go check on my other patient and I'll be back in a few minutes. I want to talk to you more about it. And that - that woman's going to say, okay, fine. I mean, they're going to be - they're going to be so accommodating to you that you can go and you can take care of your other business. Then you can come back and spend another two or three, five minutes. And then you can jump - and that's all right.

You don't have to sit there and say I've got to find this block of time to do one-to-one. You don't need to do that. You can do it in these bits and pieces and it's just as effective. And - and battered women and elder abuse survivors are going to be very patient with you as you do that.

[Jim McGraw] What - you described hovering.

[Dan Sheridan] Yes.

[Jim McGraw] The caretaker, the care provider, lover, whomever who won't separate from the named patient. Yet you also tell us that we should interview the named patient privately. How do we extricate -

[Dan Sheridan] Okay.

[Jim McGraw] - the hovering person?

[Dan Sheridan] I can give you a couple of examples of what I've used a few times and they've worked. And each instance has to be unique in of itself, but whether we need a urine specimen or not, most patients show up to a health care facility and they think they have to provide one. We may not have any need for one.

So I have literally gone up to women who I think, or elderly people who I think are being abused and I say, well, why don't you - ya know, I'm your nurse. I'm Dan. I'm one of the nurses. Why don't you come with me, we need a urine specimen.

Now that hovering

[making air quotes]

"alleged abuser" isn't going to follow them into the bathroom to watch them go. So I will actually as a nurse walk right into the bathroom with them and say, really, I didn't need the specimen, but I couldn't think of any other way to separate you. I needed to ask you a few questions. Is it okay? And even when people have said, oh, no, I'm not being abused, people don't - don't get mad at me. They don't get mad. I've had more women say to me, Well, God, I'm so glad you're asking. No, my husband's not abusive to me, but I'm so glad you're asking me because my sister was beaten, or my mother was beaten, or my first husband 20 years ago beat me. I've only had one woman who really has flipped out. How dare you say that my husband's an abuser. And I think she was, you know, she was in an abusive relationship.

I use another technique especially if there's been any sort of trauma. You need to go to X-ray now. Now, whether she needs X-rays or not, we'll get the wheelchair and we'll wheel her off towards X-ray. And he probably won't follow her into X-ray, so there's another way. And if she

needs X-rays, great. I'll go over or someone can go over and do the assessment while she's over in X-ray.

It becomes logistically more difficult if X-ray is quite a ways from your emergency room, but if you're lucky enough to have an X-ray unit right there, it can be another way where you can separate temporarily in order to do the assessment.

[Jim McGraw] We have a caller now, Dan.

[Dan Sheridan] Okay.

[Jim McGraw] Frances Nelms [phonetic] from Medical Center East in Birmingham, Alabama. What's your question, ma'am?

[Frances Nelms] If a husband finds out his wife is gone and he calls the local emergency department to see if she's there, what advice do you have for the ED personnel?

[Dan Sheridan] That's an excellent question, and there's a couple approaches you could take. You could really be the strict - you know, maintaining strict confidentiality by stating only what you would give to the news media. Yes, we had a patient here by that name and - yes, we had a patient by that name and - and she's no longer here. We don't know where she's at, sir. We appreciate your concern, but - but she's no longer a patient in our facility. Because you don't know if that's her husband. He might say this is, you know, so-and-so's husband. I - I'm demanding to know where my wife is.

And that is why most shelters keep their addresses secret, even to myself, I've been working with shelters in the Portland area for now four years and I only know where one of the local shelters is at. Most of these - and I don't need to know. So even if I knew the - I don't know the addresses. So I think just verify the patient was there, which is the same thing you would do if the news media called about a patient and - and leave it from there. And is that something that you feel that you would be comfortable in saying, or would it make you - would you feel intimidated if you had that call, Frances?

[Frances Nelms] I think we'd feel fine.

[Dan Sheridan] Okay.

[Jim McGraw] Have you any other questions, Frances?

[Frances Nelms] No, thank you.

[Jim McGraw] Thanks for calling. And I would suggest to the others in the audience who might have questions for Mr. Sheridan to call the number on the screen and we will be happy to have Dan answer them for you.

Dan, personally do you ever get angry when you've worked with a client, you've done this expert assessment, you've been very sleuthy and you've figured it all out and you've presented the - the patient the option of - of --- let's say there is a place in the inn, the haven says we'd be happy to have that person this evening and they say, "No, I'm going to go back home?"

[Dan Sheridan] Um-hum.

[Jim McGraw] How do you - how do you deal with your own feelings when that happens?

[Dan Sheridan] And that is one of the most difficult things to do, and that is why a lot of people who work in shelter movements over a period of time burn out. It becomes very difficult, especially if you think that that person's going to end up dead if they return home.

So there's a couple of ways. I try to remind myself that I'm not there to rescue this patient. I can't fix her life for her. I'm there to provide her choices and options. What do we do with a smoker who continues to smoke after their third heart attack? What do we do with the diabetic who's in the ER for the fourth time in six months in ketoacidosis because they're not following their

diabetic regimen? We look at it as a knowledge deficit. We give them additional teaching and we hope the next times things will get better. So I try to say it's her choice.

Now, it becomes problematic if she's choosing to return to that home and she's placing her children at risk for abuse. So and that becomes a little bit grayer. And if I think her kids are at risk, what I might say to her is, well, I respect your choice to return to an abusive home, even a situation that may get you killed - and I've said that to women. I think you're going to get killed if you go home. You know, on Campbell's assessment she scored 14 on 14. This is big time abuse. I'll say that. I'm very much concerned that you may get killed, but I have grave concerns if you bring those children back. They're at risk. And now my mandate to call the Child Abuse and Neglect Hotline has been triggered.

Some women will say to me angrily you're making me choose between my boyfriend or my husband and my children, and I'll say, yes, I am. While you as an adult have the right to go back to an abusive relationship, if you're endangering those children, then I have no choice but to notify the local child abuse authorities.

[Jim McGraw] We haven't talked much about the abusers. Is there hope that they - their behavior can be changed?

[Dan Sheridan] I think there's growing hope. Initially, especially when I first started in this line of - of work many years ago, we barely had any services for women. Now, we still need tremendous more services for -

[Text on screen] Dan Sheridan, RN, MS.

for the survivors of adult violence. Whether it's women or elder abuse, we need a lot more services. But what's begun to spring up is that we've begun to find that no one was trying to intervene with the abuser's cycle of violence. And more and more programs are beginning to develop abuser treatment programs.

We aren't finding many men who voluntarily say I'm an abuser. I have a problem. I want help. Now, those men who do say that, there has been a pretty good success rate in changing their behaviors. Most of the men who are coming into counseling are being court ordered into counseling.

While I'm a firm believer that adult family violence is a crime, I don't know if all of these people should be doing real jail time. I'm very much in favor of convicting these abusers of the crime and ordering them into counseling. And there are some wonderful model programs. There's something called the Duluth Program that has been a model people are using. It is both an anger control and an abuser treatment program. And we are finding some - some limited success if the man is relatively young, he doesn't have a 30-year pattern of being abusive, that there can be some hope in breaking his cycle of violence.

But just - now, the abuser treatment programs are only a couple of years old around the country and - and there's a lot of preliminary data that says that they're probably going to be helpful, but we're still trying to figure out what works.

[Jim McGraw] One of the last things I'd like to ask before we run out of time is what if your assessment and your - your gut tells you that without question there's abuse going on, yet the client denies and denies and denies, says you're wrong, Dan, you're wrong, you're wrong, you're wrong, and just refuses to acknowledge there's a problem, is there any -

[Dan Sheridan] Sure.

[Jim McGraw] - last thing you can do?

[Dan Sheridan] What I don't want to do is I don't want to be abusive to the patient who is in big time denial and minimizing and strip away their denial. To me, that's abusive. But what I'll do is

I'll say to the patient - and I'm going to pick up this card again - I'll say, you know, I understand that you're telling me there's no abuse going on, but I'm just going to leave you this card in the room. This is a card that has abuse hotlines on it, elder abuse or battered women. And you may know somebody who's being abused. And I'm just going to leave this card in the room.

If you don't want it, fine, you can throw it in the garbage, or you can leave it here, or you can take it with you. And here's my business card. If you ever have a need to talk, here's my business card. And that works.

[Jim McGraw] And they sometimes pick it up?

[Dan Sheridan] Yes, they do.

[Jim McGraw] Thank you very much, Dan, for a very informative presentation.

For those of you who are watching this program live, please remember to fill out your program evaluation form.

[Music playing]

[Jim McGraw] Site coordinators, collect these and send them along with your site roster to the address listed in your presentation packet.

For those of you who are watching this program on tape, you need to follow the instructions included with your CECH package.

I'm Jim McGraw. Thanks for joining us.

[Credits on screen] ENA Executive Director: Steve Lieber, ENA President: Marilyn Rice RN, BSN, MPA, CEN, CNA, ENA Director of Education Services: Zeb Koran RN, MSN CEN, CCRN

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