

[Text on screen] The American College of Nurse-Midwives presents
No Woman Deserves to Hurt: Domestic Violence Education for Women's Health Care Providers
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Presenters: Pat Paluzzi, CNM, MPH, Dan Sheridan, RN, PhD(c)

[Pat Paluzzi] "No Woman Deserves to Hurt" is the theme of the American College of Nurse-Midwives Initiative on Domestic Violence Education for certified nurse-midwives and other women's health care providers.

I am Pat Paluzzi, a certified nurse-midwife and senior technical advisor for the American College of Nurse-Midwives. I'm going to take a few minutes to introduce you to this video training package. What you're about to see is an edited version of an eight-hour presentation done before a live audience of a variety of women's health care providers. The original presentation occurred in Portland, Oregon in March of 1996.

[Book and video sitting on table]

[Text on screen] Five Manual Sections: Learning Objectives, Overview Materials, Action Strategies, Other Activities

We have included in both the video and the companion manual all of the overheads and slides used at the live presentation. The manual includes additional materials we feel are valuable resources. Also, the introduction in the companion manual contains recommendations on ways to use this set as either an individual or group learning activity.

Working with survivors of domestic violence can feel overwhelming to us as women's health care providers. In our clinical roles we are often able to respond quickly to the needs presented to us by the women in our care. Domestic violence is different. It is a multidisciplinary problem, and it requires a multidisciplinary response. For many women in abusive relationships, a woman's health care provider may be her only access to acknowledgment and information in how to cope with her situation. By adopting universal screening for domestic abuse of all women who present to care, we have become a part of the solution. We feel that the information contained in this video training set will increase your comfort level as you begin to work with survivors of domestic abuse. As women's health care providers, we truly believe that no woman deserves to hurt.

My name is Pat Paluzzi and I work for the Special Projects Section of the American College of Nurse-Midwives. My primary responsibility there is to direct the Domestic Violence Education Project, which is a three-year federally-funded project from Department of Health and Human Services. And through this project we have developed written materials and are running seminars such as this to train clinical nurse-midwives and student nurse-midwives about the issue of domestic violence, how to assess, intervene, refer and advocate.

The goal of this project is not only to give you the information, but we hope that, within a fairly short period of time all nurse-midwives will be asking all women who present for care as part of their screening for any obstetrical or gynecological or other type of visit that you're doing, whether or not they feel safe in their relationships, that this is an important piece of the care that we provide, and needs to be done universally.

I'm going to be one of your speakers today, as well as Dan Sheridan. Dan is part of the advisory board and our consultant list which we have as a part of our project. He is an registered nurse in

this area with Oregon Health Sciences University, is a family violence consultant, has started a few programs around the issue of domestic violence, and we're really happy to have Dan with us. [Text on screen] Begin Section I: Demographics, Dynamics, and Definitions of Abuse. Pages 19-45 in the manual.

Section I: Definitions, Dynamics and Demographics. A: The Dynamics and Social Origins of Abuse. Pages 21-23.

[Dan Sheridan] The programs that I have set up both in Chicago and then initially here in Portland deal with women right after an acute beating. I would see them after they're hurt, sort of like the pictures that you saw of the women in the video. And I would see them and they'd make comments like, "Why me, God? Why is this happening to me?" And my best explanation to the women that I work with that why they're being beaten is simply because that they're female.

I, and many of us who do this work, believe very strongly that at the root of most domestic violence, most intimate partner abuse is patriarchal - a patriarchal history of abuse combined with learned social behavior. Now let's talk about the patriarch for a minute. Who here has heard the term "rule of thumb?" A good rule of thumb to follow?

Okay. Does anybody here know the history of that? You know, I think because - I'd normally have you say it, but because of the video, I'm going to talk about it. In essence the rule of thumb were laws in this country that were actually based on English common law that gave me the right, as a husband, to physically chastise, they didn't say "beat," 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 law on the books in the mid-1970s. It was an old law. It was a Pennsylvania law 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. It was boy logic, but what was the logic to why I couldn't chastise her after 10:00 at night?

[Class Participant] Disturbing her neighbors.

[Dan Sheridan] Her screams would disturb the neighbors. So they legislated me. I mean, of course why couldn't I chastise her on Sunday?

[Class Participant] It's God's day.

[Dan Sheridan] God's day. Day of rest. I gotta rest up on Sunday, so first thing Monday I can chastise her. It - you know, we chuckle at these laws, but we wonder where has all this abuse coming from? It's always been there. Now, when our country was founded, did we have founding fathers or founding mothers?

[Class Participant] [Founding fathers.]

[Dan Sheridan] And our founding fathers had this wonderful statement. They said what, all -

[Class Participants] Men.

[Dan Sheridan] - are created equal. Now, all men are - is that what they meant?

[Class Participants] Yes.

[Dan Sheridan] No.

[Laughter.]

[Dan Sheridan] No, they meant all white men who own land are created equal.

[Laughter.]

[Dan Sheridan] Which was a novel idea for its day. But we wonder where is this, all this abuse coming from? It's coming from a society that has never really valued women, where women were considered chattel, where it was legal to beat a wife and - though she had no legal recourse -- a country where we had laws on the books for decades that made it illegal to beat animals, but yet we could beat our children and our wives.

[Murmuring]

[Dan Sheridan] My idea of a verbal argument growing up in Chicago was two guys would square off. One says, "F you." The other's "F you, Jack." That's the extent of my verbal conflict skills. Then you'd have the fight. Now, I have two sisters. Were they socialized to fight with fists or with words?

[Class Participants] Words.

[Dan Sheridan] With words. And, boy, they got good at it at a very early age. Now, all over this country today little boys are still being socialized to solve conflict immediately with fists, and little girls get very good and a lot of practice at verbal conflict skills. Now, you take this young man and this young woman and they're living together. They get married and they have that first great big disagreement. Who wins the verbal argument?

[Class Participant] She does.

[Dan Sheridan] Who wins the fight?

[Class Participants] He does.

[Dan Sheridan] He does. So a lot of the intervention programs that are going on now trying to break the cycles of violence are working with young boys and young girls, but especially young boys: first grade, second grade, third grade, fourth grade, beginning to teach them verbal conflict resolution skills.

[Text on screen] Section I: Definitions, Dynamics and Demographics. B: Cycle of Violence. Pages 21-25.]

[Dan Sheridan] One of the earliest people to talk about domestic violence was Lenore Walker. She did some early work back in the mid-70s, and she developed a cycle of violence that was sort of a circle, where you'd have sort of this initial phase where everything was sort of new and the relationship's wonderful. And then, sort of, tension begins to build. And there's sort of a violence that erupts. Then there's a reconciliation phase. And it's sort of like this circular pattern. And this sort of thing really does help explain for a lot of the women the violence they're in. Walker's theory is a wonderful theory. It's a wonderful model, but all women don't fit this model where you have this circle, this cycle and this circle of violence. Okay? But it is one of the things that you'll see quite frequently.

What you tend to see, instead of this nice cyclical cycle, is periods where the relationship starts. You have sort of this escalation of violence. Then things get really fine for awhile. Then you have this period of relatively no violence. And then you have this period of violence again. And then you have - it just sort of cycles. And this could be three days, three months, three years. So you could look at this model, but what you see over time is that the intensity and the frequency of the violence tends to escalate over time, okay, versus some sort of a predictable cycle of violence. And many of us find that this explanation is a much better, much better way to view some of the violence that we work with in women's lives.

When you have identified one type of violence, and if there are multiple generations of people in that home, you're gonna have multiple types of violence that goes on. Family violence for many is exactly that. It's family that starts in utero with battering during pregnancy, the abuse of the woman. You'll have child abuse and child neglect. The term that you'll hear, you know, intimate partner abuse, I think is probably the most inclusive of terms.

Even though about 90 percent of intimate partner abuse, the violence is being perpetrated by men onto women - by men onto women, about five percent of intimate partner abuse, it is the woman who is violent towards the man, and you truly have a battered man. You truly have a battered man. He's not the violent one. He's not trying to control her. And about five percent of intimate

partner abuse is violence within a gay-lesbian relationship, where - where one of the people is being violent and controlling of the other. And that can be an extremely difficult situation for the person in the gay and lesbian violent relationship, especially if they're not out about their homosexuality, because the other person will threaten to out them.

They may have limited resources. They may be - if it's a gay couple, he may be afraid to call the police because of all the homophobia stuff that's going to be happening and the teasing about, oh, you can't defend your - I mean, all these sorts of these things can complicate them seeking resources. So we need to try to keep in mind that there are multiple forms of violence.

Battered women are not those [Class Participant] those welfare women, those poor women, those black women, those Hispanic women, those Native American women, those Asian women. Battered women are all women.

The numbers that are out there show that the incidence of violence is fairly equal among all social, economic, religious subgroups. If there was one group of women that was at higher risk than any others, we could concentrate our intervention efforts for that one group and really try to make an impact. We can't. We have to concentrate our efforts and our level of suspicion for all women. For all women.

There does seem to be a slightly higher lethality of women who are poor. Now, that poor could be white, and it could be black, and it could be Asian, and Hispanic. It doesn't matter. But the common denominator is poor, that we do tend to see a slightly higher number of poor women who end up dead.

Now, the best theorists on this have decided to start of looking at the reason for that is among poorer individuals people tend to carry a weapon on them more often. And if you have a weapon on you, you get into a domestic, you're like to use it. Now, there's maybe some truth to that.

[Text on screen] Section I: Definitions, Dynamics and Demographics. C: Definitions of Abuse. Pages 26-32.

[Pat Paluzzi] I mean, isolation is the big one, one that we have to keep in mind when we're talking to the women, when we're taking care of the women, when we're assessing them, because they - we may be the only people that they have to speak to or that they feel safe speaking to, and the isolation is a huge piece of the abuse.

Definitions. In the back of the module you have a list of definitions in one of your appendices. And when you have a few moments, you want to read that. Because I think that when we think of abuse, often, another one of our myths is that we think of physical abuse. And I think one of the things that the women in this video say loud and clear is the emotional abuse is some of the more harmful effect, and that - the more lasting effect. And often when you do see abuse in a relationship it may begin at first with emotional abuse, long before physical comes into play. Physical may never come into play in an abusive situation, and that's something else that you need to keep in mind when you're doing assessment, that - we're going to talk a lot about what questions to ask and how to ask the question, but you don't want to frame your question just looking for physical violence. You want to look for situations that involve emotional abuse, as well as sexual abuse must also be considered.

And often you see the situation beginning with some emotional abuse, where he begins to wear her down and begins to control her emotionally, and then the physical piece and the sexual pieces can come in further on down the road. That is not always the pattern, but that is often the pattern. Financial abuse is another one, and this is a problem often more for the middle class and upper middle class. And not just them obviously, but this is one where maybe everything that she owns, everything that she has is in his name and she feels trapped emotionally, or financially in

that situation. How to take care of the kids. Or she doesn't want to dirty his name. Maybe he has some sort of importance in the community and he threatens her in that way. He controls her in that way. We have to keep all of those in mind.

The kids, to talk a little bit more about the kids, because this is an important piece of it. When we talk about - talk about abuse and we talk about our response to it, we recognize abuse as a public health issue. And the reason that we talk about it and recognize it as a public health issue is because of all the ramifications beyond the woman and that partner and that one situation.

Her children, the workplace, the misuse of the medical community, and all of the other resources around us. Homelessness. Something like 50 percent of homeless women are on the streets because they are fleeing abusive situations. It's estimated that another 80 percent of runaways are running away from abusive homes. So this impacts society in immeasurable sorts of ways.

There have been a lot of statistics, although a lot of them are under question, but there have been a lot of statistics about how the medical system is used by women in abusive situations, extreme numbers of use, visits to the emergency room. There certainly is higher risk for suicide, as one would imagine, and abuse of those sorts of services.

There is one estimate that 63 percent of all boys age 11 to 20 who have been arrested for homicide killed their mother's abusers. I don't know how valid that statistic is, but it certainly is one that makes you sit up and take notice.

That children that grow up in abusive homes are six times more likely to commit suicide. There's a lot of talk back and forth, and no one I think really can say for sure what happens to young boys or young girls who grow up in abusive homes, but certainly the young boys are at much greater risk for being abusers themselves. For the young girls, they're not necessarily at greater risk for ending up in abusive households, but often have more difficulty leaving, will stay in the relationship longer.

[Text on screen] Section I: Definitions, Dynamics and Demographics. D: Barriers to Leaving. Page 33.

[Dan Sheridan] You heard the question: why does she stay? and I want you to rephrase that. Her barriers to leaving. And I'm going to put down a whole bunch of letter Fs here. Now y'all heard the F word? You know, the big one? The one that I won't say because we're being videotaped here. Battered women - we've never used that word, I know. We've heard it. Battered women hear that word all the time. They hear that as he's abusing her, as he's choking her. I'm going to kill you, you F'ing this, F'ing that.

Now, when we talk about barriers to leaving, we're going to talk about a whole bunch of F words that you can say in public. Okay? And I want you to help me identify what is her number one barrier to leaving?

[Class Participants] Fear.

[Class Participant] Finance.

[Class Participant] Financial.

[Dan Sheridan] I heard fear and financial. And you know what, they're very close, but it's believed the number one barrier to leaving is fear. What has he said to her?

[Class Participants] I'll kill you.

[Dan Sheridan] If you leave, I'll kill you. If you leave, I'll kill you and the kids. Or he'll say I know you can hide from me in shelters. I know there's shelters out there. But see, I know where your mother lives. I know where your sister works. Go ahead, leave. I dare ya. Go ahead. Leave. I dare ya. Fear. Fear.

Homicide statistic. A little aside here. There are 6,000 women killed in this country every year, 6,000 known homicides. There are a couple, another thousand women who literally disappear, but of the 6,000 known homicides one-third, or 2,000 women, are killed by the boyfriend, the ex-boyfriend, the husband, the ex-husband. Almost every single one of those women was in the process of leaving when they died. Leaving is the most deadly time. When I ask a woman has he ever said anything to you if you threaten to leave, women will say he has threatened to kill me if I leave, and I say to her believe him. He is capable of doing it. It is the most deadly time. Fear. Fear of actually dying, coupled with fear of the unknown. To leave him means to give up everything, everything that she knows to go out there and start all over with him harassing her every step of the way. Fear. Followed closely by finances.

Followed closely by finances. Even if she's working. Even if she's working. Even if she has control of her own money, which is rare in abusive relationships, but even if she did, leaving means the income, if he's working, it's cut in half. Remember, these are not "poor women." These are women who are - often have, you know, mortgage payments and they have the 2.2 cars and the 2.2 kids and, you know, these women have - you know, it's a two-income family. And to leave means to give up the house and to sell the house and maybe the kids have to come - you know, not participate in all these piano lessons and all you know, finances can be a big problem.

What other words?

[Class Participant] Failure.

[Class Participant] Family.

[Dan Sheridan] Family. Ah, let's do family and let's do failure. Family pressures to make it work. Family pressures to make it work. Oh, he's not so bad. You know, your father used to beat me much worse. You know, he - at least he's got a job. Or maybe her family has bailed her out 10 times, and now her family is tired of bailing her out, because every time she'd run to mother's house, he'd come over and kick in mom's door, or trash mom's car. So family pressures combined with failure.

She's left multiple times and each time that she's left, he's found her and drug her back, literally drug her back, beating her for leaving. Or she's reached out for help to the police, to the health care, to friends, and - and each - and everywhere she turns she's not getting the help she needs to stay out. She feels like a failure. And of course he's doing everything possible emotionally, verbally, psychologically to contribute to her feeling like a failure. Any others?

[Class Participant] Faith.

[Dan Sheridan] Faith. Marriage is for life through good times and bad 'til death do her part, and that's when some women do part. If I have a woman who has a very strong faith belief that she cannot leave this relationship, this marriage - I have worked very closely with the ecumenical ministry councils, I will try to find a husband chaplain, someone of her religion who will say to her she doesn't have to die a martyr in her home, you know, in her home. It's okay to leave.

How about father? She wants those kids to have a father. She doesn't want to be one of them single moms out there. And as long as he's being an okay father, she will stay in that relationship for a long time. But when his violence begins to spill over to the kids, or her little boys, especially, begin to mimic the father's violent behavior, the little light bulb goes off. Women are socialized to be "mothers," that role to be more important than their role as a woman, and they will take steps to protect their children.

That can be a prime time that you can intervene. You can actually say to her, well, you know, if you don't do it for yourself, can you do it for your kids?

[Class Participant] Face?

[Dan Sheridan] She's - to save face because of the shame that goes on. How about - how about full? She stays because we gave her that wallet-size referral card. We gave her that bathroom pull-off. And she called every shelter and every shelter was full. In this tri-county area that we're sitting in right now 9 out of 10 women who called last night, tonight and tomorrow night, 9 out of 10 women who call the shelters in this tri-county area are gonna be turned away because the shelters are full. The shelters are full. We have 3,000 animal shelters in this country. We have 1,000 shelters for battered women. Kinda shows where our priorities are at.

She stays because she's got this fantasy - she's got this fantasy that she's going to fix him. Now, there's a particular profession that I'm very familiar with that is full of a lot of fixers. Do you know that profession?

[Laughter]

[Dan Sheridan] So if you have a nurse, nurses, we're fixers, right? I mean, that's why we all went into nursing. If you have a nurse who's being beaten, she's going to fix this guy. She's going to take that psycho-social nursing 101 skills that she learned and she's going to fix him. She's going to change him.

How about familiarity? She stays because she is so - all she's known her whole life is abuse. Her mother was beaten. Her grandmother was beaten. Her first boyfriend beat her. Her first husband beat her. Her second husband beat her. I've had women say to me, well, don't you beat your wife? And I'll say, no, I've never hit Marge or any woman, and that there are millions of men out there who are not abusers. And for some women this is like news because all they've ever known are men who are abusive. And these are women from middle class, upper middle class families.

And how about the last one? I'm sure there's a bunch more. How about fatigue? She stays because she is too emotionally and physically exhausted to leave.

[Text on screen] Section I: Definitions, Dynamics and Demographics. E: Cultural Barriers. Pages 34-43.

[Dan Sheridan] The cultural realities. The Hispanic woman who is here undocumented, or maybe she's documented, but her boyfriend or husband is not documented. Or maybe he's documented, maybe he's here legally, but she's not, and he has said to her that if you tell, you go to the police, they're going to deport you back to Mexico, or back to South America, or back to the Middle East, or back to Asia. So this whole issue of women with documentation. And again, the cultural issues of trying to protect him from the immigration system. The immigration system.

[Pat Paluzzi] That's another aspect of the lesbian situation because - there - I mean, certainly it's one thing to be a lesbian and to have to deal with homophobia is society, but then do lesbians as a community want - want the word to be out that there's lesbian battering? Nuh-uh, no way, you know? And so, there's a lot of pressure within community to hide that and to not acknowledge that. There's not a lot of permission there at all to out that behavior, because that's just even worse. Who needs that? You know, it's already bad enough, you know, the image of lesbians, let alone lesbians beating each other up. So it runs across a lot of facets of the cultures.

[Dan Sheridan] There is some legal confusion right now. There have been some laws that have been passed that if a woman is not a documented - is not here legally, some sort of a documentation issues, but she has children who are U.S. citizens by birth, that if she's in an abusive situation, she can more readily get documentation status to be here legally.

There's also a law now that says even , even in the absence of having children that are U.S. citizens, the fact that, if she's being abused and to be deported would be to sending her back,

especially into maybe the town where he's from and she's from, and that's going to be putting her at risk of harm because his family's back there in Ecuador, or South America, or in Mexico, that we'd be putting her at risk, she can petition the Immigration Service for documentation status to stay.

One of the things that I've heard that I don't necessarily agree with is that if - some people say, well, in their culture this is acceptable behavior, and therefore we really shouldn't be interviewing now that they're here in our culture. And I can't agree with that.

So I think, you know, some of the cultural issues I think we have to be sensitive to them, but again we can't - if a woman in an abusive situation, we can't then say, well, I guess it's okay because in that culture that's just the way it is.

[Murmuring]

[Dan Sheridan] I think we have to do that educating and that changing. And, yes, we're going to be running into some cultural barriers. We definitely are. But again, trying to work with that community and what sort of options and choices are there.

It may be culturally inappropriate to refer some women into "support group," if, in that culture women in groups is not something women do. They don't - maybe they don't do groups in the - but maybe getting that woman into some sort of individual counseling would be more culturally sensitive, and culturally appropriate intervention. But we still intervened.

[Text on screen] Section I: Definitions, Dynamics and Demographics

Begin Section II: Assessment. Pages 47-69 in the manual.

Section II: Assessment. Issues in Pregnancy. Pages 49-50.

[Pat Paluzzi] One of the things that, I'd like to start with is to say that abuse during pregnancy occurs more often than hypertension, gestational diabetes or any other antepartum complication. And that should say everything to us as clinicians, because we spend a lot of our training learning about how to differentiate the normal, detect the abnormal, treat the abnormal, you know, on and on and on with the normal versus the abnormal.

If this is a complication of pregnancy that occurs more often than any other antepartum complication, then we need to be assessing for it every time we see a pregnant woman, every time we see any woman, but particularly during pregnancy, because it is going to be present. If we do not ask the question, we are not gonna be diagnosing it and we're gonna be mismanaging our patients.

When I put up things like red flags, and we - when we show you effects of pregnancy, these are not meant to be why you ask the question. You know, these are meant to say that if you ask the question and you get a no, but you begin to see these things, you pay attention. You perhaps again, maybe not that visit. Next visit you ask the question again. Perhaps you ask the question a little bit differently. You use this - maybe one of these things, if you see them as a starting point. But that's what the red flags are for, is to up the ante in your mind of the possibility of abuse in this situation so that you document that. If you're in a service, a large service where there's five or six providers that are gonna see this woman, that they pay attention, that she said no. Maybe your form has a little checklist and you're gonna check off that she said no to abuse in her relationship, but you're gonna chart something along this line that's gonna cue in the other providers to be looking for this a little bit more.

There have been several studies that have been done that have looked at pregnancy and how often does it occur. And the most commonly accepted range is somewhere between 7 to 15 percent of current pregnancies where the women have been questioned, that there has been abuse that has occurred their pregnancy.

Who's at risk? Everyone is at risk. There might be some cultural effects, and this is debated back and forth. Now, there have been some studies which have shown that they thought that in fact, increase - abuse might increase during pregnancy for the white population; stay the same, I believe it is, for African-American population; and decrease for Latina-based populations. However, then they come right behind that and people will say it's a difference in reporting. It's a cultural effect of the difference in reporting. So pretty much there's nothing that's very valid that looks at that there is a change amongst cultures.

Um, some of the people who might be at increased risk are teenagers. Again, this may be because they are receiving dual abuse. They may be being abused by a family member such as a father or an uncle, as well as the father of the baby.

Drug abuse. Drug abuse and physical abuse, it's pretty convoluted sometimes, and it's hard sometimes to sort it out. What we know is that if the batterer is also a drug abuser, that those are two very separate issues, that often he may use getting drunk or getting high to empower him in a way to move forward in the abuse, and it may look like if only he would stop drinking, he would stop abusing, but in fact they're two very different problems and require two different treatments. So if you have an alcoholic abuser and he stops drinking, you just have a non-drinking, alcoholic abuser. So there's two different forms of treatment that have to occur there. If it's the woman is abusing drugs, what we know about women who are addicted and drug abusers is that the vast majority of them become addicted following a traumatic event, that this is much more common in women than it is in men. It's much more the profile. This could be childhood sexual abuse, this could be abuse during that relationship. But again, it's a separate issue. It may be her way of coping, of trying to cope where the situation in her life, requires separate treatment. But he may be using this in some kind of ways, either getting her high or when she gets high, you know, that's his excuse to beat her. But those are separate issues. And unintended pregnancies. There have been a couple of studies that have shown that in fact abuse occurs more often in unintended pregnancies. So those are some of the things that may somewhat increase risk.

Why has this happened? Again, we don't know why anybody abuses another individual or why they would do it during pregnancy, but some of the theories are that there's - it's a sign of commitment or there's increased jealousy. One of the theories about abuse is that some - often it doesn't happen until there is some commitment in the relationship. They've moved in together. There might have been some subtle signs, but maybe it doesn't escalate to a point until there has been - they get married, they move in together, there's some sort of commitment. Pregnancy certainly is going to be seen as a form of commitment in a relationship, if you're going to have the person's baby.

And jealousy. The woman is now perhaps not as focused on him as she once was because now she's pregnant and she's turning some of her attention into the baby, and that could fan the fires for him. Again, these are just theories.

What are some of the effects? Some of the effects of pregnant - of abuse during pregnancy. We have both behavioral effects, emotional effects and physical effects for both the mother and the fetus.

Some of the physical effects to the mom and to the baby. During pregnancy often the trauma to the breasts, abdomen and genitalia may increase, that they become more a focal point for the abuse. So certainly we ask clinicians if we see any of these things need to question them, need to document them. Chronic pelvic pain has been documented.

Recurrent sexually-transmitted diseases. We talked about sexual abuse. Sexual abuse doesn't always mean rape. It can mean controlling whether or not this woman is able to contracept. It can mean controlling whether or not this woman is able to practice safer sex, and recurrent STDs are seen as he will be unfaithful to her and not allow her to protect herself in any way from that.

Um, poor weight gain in pregnancy has been documented. Signs of post-traumatic stress disorder, as we talked about. Abruptio placenta and spontaneous loss, pre-term labor and delivery. For the baby, fetal effects, low birth weight, prematurity, fractures and cranial bleeds. And to talk about low birth weight for a minute, there has been a couple of studies that have been done that have pulled out like, all of the other risk factors that may have been pregnant - occurred during the pregnancy and controlled for them like cigarette smoking, weight gain, socioeconomic status, entry to prenatal care, etcetera, etcetera, and still low birth weight shows up as occurring more often in cases of abuse during pregnancy.

Again, another marker for us as midwives. You know, if you see this in someone's history perhaps, you're gonna be more careful as to how you ask or how you frame the question. You have reference now what you document, how you document.

[Text on screen] Section II: Assessment. B: Asking the Question. Pages 51-52.

[Pat Paluzzi] You have an example of an abuse assessment screen in your packet, and this is one example of some ways that you can ask the question. But some general sort of rules about asking the question. Always ask the question in complete privacy.

Now remember earlier that Dan mentioned that there can be abuse in lesbian relationships, so you cannot assume because it is not a male partner that everything is okay and that you can ask in front of this woman, this other woman who's with her.

You cannot assume that it's okay to ask in front of the mother. You don't know if the mother - if she's not gonna say anything when the mother's present because the mother already knows, or she doesn't want the mother to know. You can't make any assumptions about anybody that's with her. You have to get her alone.

Some creative ways of getting her alone are follow her into the bathroom for a clean-catch urine if that's the only way that you can manage it.

As we've done the workshops people who have begun to put this into practice in their offices have begun to generate policies that they use across board, which is at some point in time during this woman's intake, in pregnancy in particular, there is built-in time that you're gonna be alone with her. And it could be during your history taking part, it could be during the pelvic part. You pick it.

Whatever suits your style and your office the best. But practices are coming to the conclusion that they need solo time with these women in order to do a good accurate history. And it's during that time that they're able to ask the question. You don't need a lot of time, but you do some to have her completely alone.

Best not to ask yes or no questions. You know, you want to have more conversation that comes out of a result. You remember the first woman who said I - I wasn't a battered woman. I wasn't a battered woman. You know, and often if you say - so, you can't say do you feel like a battered woman? Do you feel you are abused in your relationship? More than likely they're gonna say no. I mean, they're not gonna relate to those terms necessarily, particularly if they haven't outed this information to anybody else up unto this point. You're gonna have to be more creative in how you ask this in order to get some responses. She may not see herself as battered or abused. So, you can figure these out. You know, how is it that you want to ask the question? Because one of these barriers we sometimes have as providers is we're afraid we're going to offend. You

know, we're afraid that we're gonna ask some woman and she's gonna look at us like how dare you ask me that? Why are you asking me that? You know, there's nothing wrong in my relationship and why would you ask me that?

I will tell you in my own personal experience no one has ever said that to me. In fact, people have said the opposite. Often I've heard, you know, no one has ever asked me that before. Thank you for asking me that. And this is often when there is no admitted abuse. So, I think that, you know, you won't get a lot of why are you asking me that? Why are you invading my privacy? And if you do, perhaps you want to like look at that a little bit more closely.

But maybe what - if it makes you feel more comfortable, in the beginning, you tell everybody this is a widespread problem. It's now policy. It's now my standard part of an intake, just as I'm gonna ask you about other things in your history. You maybe, what I would suggest as one method is to look at doing a social history, which I'm sure you all do to a certain extent, but you wanna broaden your social history.

Your social history is where you can ask about childhood sexual or emotional abuse, where you can ask about substance abuse in greater detail, and where you can ask about the current and former relationships and the potential of abuse in those relationships.

Often our forms don't have all of these things on there or they have a little checklist and you may have to find a place where you can be a little more creative in documenting that. The last place I worked we used ACOG forms and we used to put it under the genetic history thing, and we would just handwrite it all in.

And pretty soon everybody was copying us. It was really kinda wonderful to see that as we started doing this, you know, everybody started getting - the residents starting saying, God, this is really a great thing to read this. We're gonna start doing this. So you can be creative with your forms.

But perhaps you wanna just say this next part of my history is gonna be a social history, and I'm gonna ask some questions that are rather personal. Please bear with me. I think they're very important. You know, my intent is not to harm, and whatever it is that makes you feel comfortable as your entrée into that.

Okay. And again, Dan's gonna talk a little bit more, but you want to be specific enough in asking your questions to talk about how do you and - you and your partner resolve conflict? And in the middle of resolving conflict, or in having fights with your partner do you ever feel afraid.

[Text on screen] Section II: Assessment. C: Responding to the Answer. Pages 53-59.

[Pat Paluzzi] So you also have something in your packet of handouts called the "Women's Abuse Advocacy Protocol." And that's an important piece to look at, because what that does is it takes you very quickly through. If you have a very brief intervention with this woman, what is - what are the things that you can kinda focus on, to make the most out of this bit of time you have?

Because the truth is that if you have now 15 or 20 minutes for a prenatal visit, you're working in luxury these days. And it's gonna get worse. It's gonna get harder. And we're asking you to do more. We're asking you to take on big chunks of social history, and to address all of this stuff in short periods of time.

So, to be reminded that just asking the question is an appropriate intervention, if you can do no more during that visit, because what you've done when you've asked the question is that you've offered an opportunity, if she responds to you, to validate her experience. And that's an important piece. You want to be able just to validate for her that in fact this abuse exists. Because as Dan mentioned earlier, there are women who think that it happens to everybody, or he's been telling

her all along that, you know, not really convincing her that she's abused, that she's crazy for thinking that he's this, he's that. You know, making it her problem.

So by your asking the question, by your responding, by saying I believe what you're telling me, no one deserves to be treated this way, things such as this, you are validating the experience for her in a way that it's not being validated in other situations. And that often can be the first step for her to begin to go home and look at this in a way that she might be able to take and move from.

Empathizing with her. Again, you're telling her that you do not believe that it's her fault, and that you care about what happens to her. She may not be hearing this anywhere else in her life at this point in time. It also gives her some space then maybe to come back to you to talk to you some more, as to begin to build a relationship.

Um, you may want to generalize the response a little bit because she might get uncomfortable, particularly if it's the first time that she's responding yes to this question, if you begin to focus in way too much. So maybe your initial response is to kind of generalize. This is a large problem. I can be of service. There are some resources, that sort of things, without getting right into a place where it may be way too intimate, way too fast for her.

And empowering her. And this is an important piece of this, because as we will see as we talk about women's choices to leave or to stay, she has her own changes and her own movement that she's gonna make in this process, as she comes to a place where she feels like she can take whatever her next step may be. But in order to be able to do that she has to begin to feel more empowered again as an individual, because through the control and through the battering she is losing all of her power.

That is what it's all about, is she's losing all of her power. He is controlling her. He has all the power. So she needs to begin to build hers back up again. So, you can say things like talking to someone can be very supportive. I can give you information for now, or for later. Because you don't want to make her feel that you are going to now direct her, you're going to tell her how to take care it. Again, she needs to make her own movement. She needs to make her own choices. She needs to make her own decisions. So, you give her information. You frame that it's for whatever use she feels comfortable taking this information. Hotline numbers, shelter numbers, whatever.

I believe that only you know what is best for you and your children right now. Whatever decisions or choices you make right now are right for you. And that is a really, really, really important place for you to stay in your intervention. And that is a really difficult place for us to stay in our interventions. And in, fact it's recommended this work be done in multidisciplinary teams.

This is not something that one provider can take on and do. And we've already sort of gotten a sense of that from our conversation this morning, that, you know, the laws are gonna be - legal's gonna be involved. Kids are gonna be involved. This is bigger than a nurse-midwife or a nurse practitioner or a physician. This is a team effort.

In the back of your module on page 27 is an - and 28, and it goes on. But to know about these power wheels. Power and control wheels. And these are one way of looking at -- when you look and you compare like a power and control wheel and then an equality wheel, advocacy wheels, medical power and control, you get, you begin to see as you look through the wheels the difference in the kind of responses, sort of the fine tuning of what we're talking about of how as providers, if we ask the question, she gives us the answer, that one response is going to just be more abusive.

You know, that if we look at abuse as an issue of control, that if our own agenda is to get her to leave, because that's what we think she has to do, we're not doing anything any different. We're using - we're abusing our control, and our power as her medical provider to continue to abuse her, to batter her into thinking that she has to leave. It's no different.

And when you look at these wheels, you kinda start to get a sense of that. And as Dan talked about, you know, our language and the way that we frame things, it becomes really, really important. When you begin to raise your consciousness, when you look at these wheels and you begin to think about how, and as providers we go there in a very quick way.

You know, we can be very maternal, paternal, whatever, you know, directing. You know, we know what we're doing. We have our little white coats. Even if we don't have our little white coats, we have our attitude, you know, and we come in and we kinda just tell you what it's all about, and how to take care of yourself during pregnancy and other - you know, and what to do. And this can be part of it. And we have to really look at that and we have to really pull back from that.

We have to really think about - because what we don't want to do ever is to kind of support his behavior. We don't want to advocate for him in any kind of way. We don't want to sort of aid and abettin' her. We don't want her to continue to think that she's this weak little thing who can't care for herself. We want to continue just to say you know what's right for you. You know what's best for you. I'll support you.

[Text on screen] Section II: Assessment. D: Communicating with Women. Page 64.

[Dan Sheridan] We as health professionals have been socialized to view a lot of people as victims. We have AIDS victims, and we have cancer victims, and we have hemophiliac victims, and in - right, recently in Portland we had a whole bunch of flood victims. And we think that victims, for whatever reasons, are temporarily not able to do things for themselves. So we as helping professionals, we come and do things to them and for them. But we don't do things to and for survivors. We work with survivors.

If you treat a battered woman as a victim, you try to assess her as a victim, she's going to turn you off. She's going to read right through that and she's not going to talk to you. Battered women are survivors. They have survived weeks, months, years of abuse, paid the bills, done the laundry, did the shopping, got the kids off to school, kept the abuse hidden from you and from her family, and she's stayed alive. She's a survivor.

One of the things that I do is I treat her as a survivor and I work with her to come up with the process or the plans, the safety plans we'll be talking about after lunch today, to come up with plans to work with her to begin having her take some of the energy she's putting into staying alive, and second-guessing his next abusive episode into making up with safe plans to begin to distance herself from the violence.

So I think the number one thing in assessment is you need to move beyond the fact that she is somehow this learned "helpless victim." She's not. She is a strong survivor. She's a strong survivor. And she's making some choices that kinda have her stuck at this point. And you've gotta help to move her on with that. But she's not a victim. She's not helpless by any means. Battered women are very accommodating. They have been accommodating their abusers for a long time. When you say to her thank you for beginning to share that, but I have to go see this other patient right, but I'll be right back, she's going to say okay. Okay. But you've acknowledged and you have validated. You've begin the process of her telling her story. It's very, very important that you give that permission.

And not only we talked about privacy, I find it very effective for me, as a man, asking women about abuse that I get on at least eye-to-eye contact with her. I don't stand above these women with my white lab coat, and my stethoscope and my little clipboard, and I'm askin' about abuse. How many people where you work have these stools on wheels that you take the chair and you get it to that lowest setting? I sit in that where she's literally looking down at me, or at least we're on eye-to-eye contact. It's a very simple technique.

But you are now going to be asking her questions where her abuser has told her if you tell anybody, you're going to get it worse. And now we're now asking you to ask her these questions. Very simple technique. Eye-to-eye contact or that she's actually looking down at you.

[Text on screen] Section II: Assessment. E: Assessing for Injuries. Page 65.

[Dan Sheridan] I need a quick show of hands of people in this audience who have never accidentally hurt themselves.

[Laughter]

[Dan Sheridan] I've had a lot of experience in accidental trauma. What parts of your bodies - forget for a minute that you are nurses, you are advanced trained nurses. Think of yourselves as people who accidentally hurt themselves. What parts of your bodies most often do you hurt?

[Class Participants] Hands and feet.

[Dan Sheridan] Hands and feet, and shins and bony prominence. And I'm six feet tall and most architects are five foot, ten. I walk into things right about here.

[Laughter]

[Dan Sheridan] Now, how many people have bent over to pick something up and on the -

[Class Participant] Oh, yes.

[Dan Sheridan] Yes, I can see a lot of people going ouch. Been there, done that. Accidental trauma is characteristically distal trauma, trauma to the periphery, while intentional trauma - throughout the life cycle, whether it's child abuse, intimate partner abuse, elder abuse, intentional trauma tends to be midline, tends to be proximal, and in a sick way tends to be sexual. It is direct and intentional trauma to the face, choking trauma to the neck, punch injuries to the breast, biting injuries to the nipple, punch injuries to the upper arm, the abdomen, especially the pregnant abdomen, intentional injuries to the thighs, penetrating injuries to the rectum, to the vagina, injuries that can be hidden by clothing.

These guys are not going ballistic. These guys do not have this impulse control problem where they just go wild and they lose control. Many of these guys know exactly where they're hitting her. They're hitting her with a purpose, they're hitting her in areas that are going to help control her, keep her isolated in that home. The injuries are often hidden and often there are treatment delays.

As with child abuse, if a woman is - a woman is going to try to take care and nurse herself at home, often will not seek treatment until the injuries aren't getting better or maybe her abuser has now gone out of town on business and maybe she can sneak in and get the appointment to see the doctor. There's treatment delays.

Now, there's a couple of forensic buzzwords I want you to write down and memorize. One of them is called a patterned injury. A patterned injury is where you have reasonable certainty what object or by what mechanism that injury occurred. That is a similar sounding word to a pattern of injuries. A pattern of injuries, as Pat referred to earlier, are injuries inflicted over time, bruises in various stages of healing, multiple rib fractures in various stages of healing, old scars, new wounds. There is this pattern; there's a time element here.

[Text on screen] Section II: Assessment. F: Assessing Patterns of Injury. Page 66.

[Photo of a woman's back]

[Dan Sheridan] I can't say with 100 percent certainty that this was caused by an electrical cord, but I'm pretty darn sure. This is looped cord-like. Now, look at the age of this and look at the age of this injury there. Are they the same age? They're not. If you look carefully, here is an old healed loop scar. This woman has a pattern of patterned injuries. If she were to say to me this is the first time my husband has whipped me with a cord, I can confront her, hopefully in a positive tone, with the fact that she has a pattern of patterned injuries.

Now, what caused this injury right over here? It's not an iron. A heel of a shoe. After this woman was down, then she was stomped on. I would document that as a patterned heel-like contusion.

Here's another patterned heel. Here's the rest of the foot coming up over her shoulder. This one is not as clearly demarcated a pattern as this one. Now, obviously you'd want to do a review of systems. Something that's causing that sort of contusion, I'm going to want to be ruling out kidney involvement. I'm going to want to be ruling out diaphragmatic involvement, lung involvement. Someone who's been kicked this high to the back, you got to rule out hemopneumothoraxes. This probably wouldn't be a walk-in clinic; this probably would be coming in through an emergency room. But we don't know if she's pregnant on the other side. We see her back right now, but if she's pregnant, okay, obviously that introduces a lot of other things we'd want to be looking at. But this woman, again, has patterned injuries and a pattern of injuries.

[Photo of a woman's breast]

[Dan Sheridan] Breast injuries are extremely common. I have photographed a lot of breast injuries. Not surprisingly, I've not had a lot of permission to show those as teaching slides, but I have photographed, and you will see frequently injuries to the breast, biting injuries to the nipple areas.

[Photo of a woman's outer thigh]

[Dan Sheridan] We would certainly suspect abuse if we saw this. This is a patterned stomp injury. Here's the point of impact from the foot. It pushed all the blood to the side. We would suspect something big time went on here, right? But how many of us have awakened in the morning -

[Photo of another woman's outer thigh and forearm]

[Dan Sheridan] - to find bruises on our thighs and we have no idea how they got there? No idea. Most likely we bumped the corner of a table, but a nurse practitioner saw this, and she also saw this little circular punch injury here, and she had a few other subtle injuries, and she said, "The injuries you have look like they may have been caused by someone. Has anyone hurt you?" And sure enough, someone had. This is what you'll see in your practices. This is what you'll see on your friends, on your neighbors, on your family.

[Photo of a woman's upper left arm]

[Dan Sheridan] Punch injuries to the arm are extremely common. She was punched twice. What arm is that? Left arm.

[Photo of another woman's upper left arm.]

[Dan Sheridan] Left arm. One, two, three punches there.

[Photo of another woman's left arm]

[Dan Sheridan] Left arm. He was wearing a ring, gave her a curved linear abrasion. Here are some more of these looped, cord-like injuries.

[Photo of a woman's left arm in a cast]

[Dan Sheridan] Okay. This woman had a mid-ulna fracture. Look at her general health. Does she look healthy?

[Class Participants] No.

[Dan Sheridan] She thought she was fat. He had called her a fat slut and a fat pig and you fat ugly - fat, fat, fat. She - she was anorexic as hell, but she thought she was fat. But maybe - you know, maybe some women - eating may be the few things some women can control. So maybe some women who are overly obese, because he's been called fat so many times, at level she thinks you this is fat, watch, and she may overeat.

[Photo of another woman's upper left arm]

[Dan Sheridan] Don't - how old is that? Can't tell is the best answer. Can't tell. Do not sit there and try to date injuries. Do not say approximately 7 to 10-day-old. We know that's not a yesterday bruise, but don't try to date it. Because if someone says - ya know, the doctor writes approximately 7 to 10-day-old contusion, and the defense attorney will point out, but, members of the jury, Your Honor, my client was out of town 7 to 10 days ago. But he was in town 6 days ago and 11 days ago.

You describe it by its size, its color, if it has a texture. And then you would write in your assessment that the bruise to her arm is consistent with her history of being hit seven days ago, six days ago. If she says was she was hit an hour ago, we know that's not an hour-ago injury. So I would write in my assessment the injury to her arm is not consistent with her history of being struck an hour ago. Okay. But don't try to date these bruises.

[Photo of the back of a woman's left arm and upper back]

[Dan Sheridan] These, if you look carefully are caused by what? See these little marks?

[Class Participants] Cigarette burns.

[Dan Sheridan] Not burns. They're not burns.

[Class Participant] Fingers.

[Dan Sheridan] Fingertips. Children, battered women, elderly are often grabbed by abusers, forcefully grabbed by both arms, squeezed, often lifted off the ground, shaken. And you'll see these fingertip injuries to the arm. You'll often see them to the neck. You'll see them to the inner thighs, to the knees for women who are sexually assaulted. And you have these little fingertips. And your first impression at a quick glance might be burns. But they're not. They're contusions. They're bruises.

[Photo of a woman's right elbow]

[Dan Sheridan] Okay. If someone goes to hit you, what are you going to do?

[Murmuring]

[Dan Sheridan] Put your arm up. But women come in all the time - and I - I would document these as defensive, posture-like contusions. A little editorial in there, but they're defensive, posture-like contusions to her arm. Now, if she comes in and says -

[Photo of a woman's lower right arm]

[Dan Sheridan] - she fell down and you look at her palm and her palm is fine, she didn't fall down. She put those arms up in a self-defensive posture. And I see a whole bunch of those.

[Photo of woman's lower left arm]

[Dan Sheridan] Look at her - she came in and said she fell down. Now, we are experts at accidental trauma, right? What do we do when we fall down, whether we want to or not? We put those hands out as a brake. Okay? Those hands go out. And if her hand looks fine and she's got these bruises here, if someone goes to hit you, you put your arms up to defend yourself. You

can confront her again in a positive way with this injury looks like it was caused by someone. Did anyone hit you? It's okay to talk to me about this.

[Photo of a woman's inner right thigh]

[Dan Sheridan] Okay. This is a punch injury. He was wearing a ring with a stone in it. A high school ring, a college ring, a fraternity ring, a ring with a stone. And again, these are often worn on the guy's right hand, right? Because if he's married, he's got the wedding band on his left hand. He wears this high school or college ring on his right hand. And when he punches her with this ring with a stone in it, it gives you a U or horseshoe-shaped abrasion in the middle of the punch injury. That has forensic implications. If the abuser is in jail and under mandatory arrest, they can take that ring and the crime lab might very well be able to find some pieces of her in that ring. Again, hard evidence.

What caused these injuries here to her thighs?

[Class Participants] Fingers.

[Dan Sheridan] Fingertip injuries. This woman's husband wanted to have sex. She said no. He said yes. She said no. You can see the sick sexual nature of the punch injury to the inner thigh and the force that he used as he spread her legs apart prior to raping her.

[Photo of a woman's face]

[Dan Sheridan] Different woman, different abuser, but look in the middle of forehead. Any time you see that U or horseshoe-shaped abrasion, you know that the abuser was wearing a ring with a stone in it.

Ocular injuries are real common. Nasal fractures. Ruptured eardrums extremely common for women being slapped to the side of the head. And they try to heal themselves at home, and that ear is just draining and it's draining. It's not getting better. And she comes in and we look at that ear and we go, "Oh, my God, what happened here?" And she says, "Well, I - I was cleaning my ear the other day with Q-tips and my toddler bumped my arm and I must have poked a hole" - no, probably not. Probably what happened is she was slapped to the side of the head, and it ruptured it on the impact, and she tried for it to get better at home, and it wasn't getting better. It wasn't getting better; it was infected now.

[Photo of woman's right hand]

[Dan Sheridan] Okay. This was an unfortunate learning case for me back when I was a new expert in this back in 1988-'89. I documented that as a four-inch what?

[Murmuring]

[Dan Sheridan] I called it a laceration. This went to court. This went to trial. I was acknowledged as an expert witness. I'm on the witness stand and the defense attorney says, Mr. Sheridan, for the benefit of the jury, could you please give the definition of what a laceration is? And - and I couldn't recite it from memory.

And he just happened to have a medical dictionary and he says, "Your Honor, I'd like to read this to the jury so they understand what Mr. Sheridan wrote." But a laceration by definition in essence is a tearing or splitting of skin, most often caused by blunt impact. "And, Mr. Sheridan, were you describing a tear and a splitting?"

I'm going, "Well, no, no, actually that was sort of a cutting sharp injury." He goes, "Wait a minute, wait a minute. You called it a laceration in your notes? You're the expert. If you don't know the difference between a laceration and a sharp injury, how can the jury believe anything else you wrote in the medical record?" He tore my documentation apart. That is not a laceration.

[Same photo displayed]

[Dan Sheridan] That is a sharp injury. That's a cutting injury. And actually what happened is her husband grabbed a kitchen knife and just kind of swung it and she put her hand up and just ever so slightly cut her hand. But I called it a laceration, and it's not.

And he also - this defense attorney did the same sort of picking apart the police documentation, and that abuser walked free. He got away with his abuse -- in part because of my documentation, in part because of the police documentation. We have to be very careful in what we write. This is not a laceration; this is a cut injury -- a sharp injury.

[Photo of a woman's face]

[Dan Sheridan] I'm going to show you a series of slides and talk a little bit about forensic documentation. You want to start out with sort of a full facial view, and then you wanna kind of hone in on the different shots. And again, she has a scale in here so I have some idea of the size. Also, this gray scale, theoretically the people who developed these adjust their colors to this color gray and it gives you a more true color than just regular. That's in theory.

Also, I can tell something else from this slide: What was she wearing when she was hit?

[Class Participants] Glasses.

[Dan Sheridan] Glasses. Okay. Any of us who have glasses know that, you know, you get banged, it hurts, and you also end up with these little bruises here. That has - that may have some very basic nursing 101 implications. If she's now hospitalized and she was hit and you see an injury sort of to the bridge of her nose, without my glasses I can't see anything. But just as some basic nursing, can you see all right? You know, the glasses probably got trashed and broke into a million pieces.

But she had a lot of facial injuries. And kinda of going through -

[Photo of the same woman's lower lip]

[Dan Sheridan] - sort of a systematic view, you know, of trying to show the various - the extent. She had - she had lower lip. And then she had sort of upper lip.

[Photo of the same woman's upper lip]

[Dan Sheridan] You know, again trying to get sort of a series of shots -- not just taking that one. Trying to show that series. Because when these get introduced in court as -

[Photo of the same woman's tongue]

[Dan Sheridan] - People's Exhibit A, B or C, all of these, each one of these can be introduced into court separately. And you can - either by your charting or in person -- you can talk about what these injuries show, and it has an impact on the jury and the judge.

[Photo of another woman's face]

[Dan Sheridan] This woman was walked into the emergency room in Chicago right before I left the program there. Walked in by the paramedics. Positive loss of consciousness. Beat up by her boyfriend. Positive loss of consciousness. Now, if she was in a motor vehicle accident, positive loss of consciousness with all sorts of facial injuries, how would she have presented?

[Class Participants] On a stretcher.

[Dan Sheridan] On a stretcher, multi-system trauma, taped down. I mean, this would have been trauma 101. I mean, you know, rule out - she was walked in by the paramedics. She could not see out her eyes they were so swollen. The ophthalmology people pried them apart. There was no retinal damage here. She had some dental fractures, so the teeth were broken. But anybody who's worked ER knows we don't do teeth in ER. We refer those out.

Look at the dissymmetry in her jaw. We thought for sure she had a jaw fracture, and she did from six months ago that was never treated.

[Murmuring]

[Dan Sheridan] That's how it healed. The emergency room physicians were going to discharge her to home.

[Murmuring]

[Laughter]

[Dan Sheridan] This - this is - we don't do social admissions, is what they said. Nothing was broken. There's nothing they could do. They were going to send her home, temporarily blind, to her abuser.

Now, she happened to be Puerto Rican and had alcohol on her breath and - and no insurance, but - but I'm sure that had nothing to do with it.

[Photo of another woman's face]

[Dan Sheridan] Okay. This woman's first husband never beat her up. Never. The guy died. A few months after she died, she went out on a date. This was her second date with her new boyfriend. Got into an argument; beat her up.

[Photo of a woman's vulva area]

[Dan Sheridan] This woman's boyfriend thought she was cheating on her, so he kicked her into the vulva area. This is a big, big painful hematoma that needed to be lanced with a Pen - put a Penrose drain in. This is a woman who said to me, "Go ahead and take the picture. And, yeah, you can use it as a teaching slide, because if by showing this slide just one woman doesn't have to go through what I'm goin' for, snap the picture."

Now, is she a victim, or is she a survivor?

[Class Participants] Survivor.

[Dan Sheridan] She's a survivor.

And then what we're going to be talking about, again, some of these further assessment questions after you've seen some of the sequelae, the physical or emotional. The injuries that you have look like they were caused by someone. Has anyone hurt you? Don't do what I did in Chicago when I was a new expert in this. I went in and I read the face sheet, and it said - the married box was checked and I went in there with my best psycho-social voice, and I said, "Ma'am, the injuries you have look like they were caused by someone. Did your husband beat you?" And without hesitating she said, no, my husband's a sweetheart; my boyfriend beat me up.

[Laughter]

[Dan Sheridan] I made the assumption it was her husband. It could be her brother. It could've been her sister. It could've been her father. So sometimes when you ask these questions, it may be better to ask them in a more open-ended way. Has anyone hurt you? Has anyone hurt you? Or when women have - again Pat went through some of the emotional sequelae, the depression, the suicide attempts, the anxiety, the eating disorders, the sleep disturbances that we can say we know that women are depressed or anxious or suicidal, there may be abuse going on in their lives, or they may be in hurt. I someone hurting you? Are you okay? Are you safe?

Again, another way to have this physical-sexual link, that we know when a woman is physically hurt she may be forced into sex when she didn't want to participate. Is that happening to you?

Again, you'll find what is best for you how to ask, but these are some general guides that we have found over the years to be extremely helpful.

[Text on screen] End Section II: Assessment

Begin Section III: Intervention. Pages 71-109 in the manual.]

Section III: Intervention. A: Danger Assessment. Pages 73-77.]

[Pat Paluzzi] What is danger assessment? It's pretty much exactly what it sounds like. It's trying to figure out, within her current situation, how safe is this individual? Because what you would

not want to do is have her tell you, "Stop right there," say here's a number for a hotline, she goes home, something awful happens because you haven't taken a minute to at least assess is it safe for her to go home? And that's really, in that particular intervention, the crux of what you should do. Is it do you feel safe in your own - do you feel safe enough go to home? Is it safe for you to go home? That's really the bottom line -- the minimal amount that you can do in an intervention. Um, danger assessment can provide a lot of other, um - um - uh, avenues for discussion, and one is to help her to see what is her level of dangerousness, as well as while you're seeing it, perhaps she's getting a picture of the situation in a different sort of way than what she might have thought about. She's been minimizing this behavior all along. She's been adapting all along. She may not begin to see this as dangerous as you might see it looking at it for the first time. So this might be a consciousness raiser for her as well if you take her through the process.

But there is a tool, which is in your packet of handouts, and it looks like this. "Danger Assessment." It's by Jackie Campbell, who we've spoken about in the past. What we're going to concern ourselves with is the danger assessment on this page. This is a tool that Jackie used to do some, um - a study actually, to try and determine if there are ways to predict the risk of homicide in given situations. Um, this can also be used then as a tool, again, to raise her consciousness and determine her safety level.

There's, um, discussion back and forth. Most people will agree that it's fine to have people fill out forms, but of course you always have to then address the forms and that often you get better responses if you do things interview-style rather than handing them to people and having them fill them out by themselves.

You can see in the questions here that there is - that, um, if there are any yeses to this, you're gonna respond to these. And what they begin to look at is types of violence, escalation in violence, use of weapons, increase in threats of killing himself, her, threats to children. Um, and when you look at these, you get a sense of that.

The other thing that you can do sometimes with danger assessment is to pull out calendars. If she can't really get at this, if she can't really ferret out is it more, is it happening more often, is you can pull out a calendar. You can have her work with you with a calendar to begin to look at when was the last time, when was the time before that, when was the time before that? You know, can you come up with it? Was it around a holiday, you know, all of the sort of things that we do when we're trying to get menstrual histories and we're trying to get people to stir up memories, if you have to use those techniques.

But you can - if you begin to get her to sort of see, she might see that in the last three months, it's gone from once a month to every other week to weekly. She might begin to see a change. And those predictors of increased violence - as Dan talked about, increased violence, increased episodes of violence, increased use of weapons and types of violence, the introduction of physical violence where it once didn't exist, sexual violence as a new thing, those are all predictors of increased dangerousness in - in a situation, increased risk for her.

So these are some of the, um - the - you know, capsulated form of some of the things that you would be looking for. When you have this information then, you just can reflect this back to her. You know, with what you've told me, you know, and what I know about the situation, this increases the risk to you. Um, because of the things you're answering yes to here, I'm concerned about you. Do you feel safe to go home? And if she still says yes, we're gonna always say to you that you have to respect that.

[Text on screen] Section III: Intervention. B: Safety Planning. Pages 78-97.

[Pat Paluzzi] Safety Planning. This is another very basic piece of - of, um, intervention that you should do with any woman. Um, and this can take again very, very multiple forms, because this can be very extensive. You have on the right side of your packet one example of a personalized safety - safety plan. This came along as a booklet with one of the videos, the one that we're not going to show, um, and it's very lengthy.

There's a good thing about this because it takes you through - and we're going to walk through it a little bit here. It takes you - makes you think about all the areas in her life where she has to look at this situation and plan for safety, which you may not think of in your own. You may just think safety is, you know, where is she going to go if she has to leave in the middle of the night? That's one example of where you can do safety planning. There are gonna be many others that we're going to look at.

What is safety planning? Um, so one of the things is what - how does she keep safe during a violent incident? And, um, that is step one in this plan, elaborated a lot more than it is up here. And you can take some time, um, yourself. And this is something that certainly is very lengthy. You would probably not use this in your practice, because for somebody to sit and fill this out for you to do an interview with this is probably more time than you would ever have. But if you have in your system perhaps advocates who are able to do some more of this, that might be a useful tool to share with them. You as a midwife are maybe not gonna be able to quite do anything this extensive. But you can take a look at it and condense it.

So during a violent incident what are the things that you might recommend? Staying out of rooms where there's potential weapons. If she sees the fight coming, you know, to try to negotiate herself out of the kitchen, you know, out of a work area, places where there would be knives, where there would be screwdrivers, hammers, those kinds of things.

Arrange for calls to 911. She's often not going to be able to be the one to make the call to 911, so she's going to have to involve other people in this. Her children, unfortunately, you know, but they're - they know what's going on. And so the point is to include them in a way that they can be of, um, you know, some helps to themselves as well as to her. Because they hear the fighting, they know what's going on, they have to be trained to call 911.

A neighbor. She may make arrangements that - for some kind of a code. If she bangs on the wall or something like that, or even if they just hear it. Maybe she doesn't even have to establish a code, but making the neighbors aware so that they're willing to intervene. They know she wants the intervention. They're willing to intervene. They're willing to make the call of 911 for her. Having the keys, et cetera, available to leave quickly and then moving on to leave. So this is a big piece. This is the one we think of often when we think of safety planning is how does she get out of there? And it's an important one, and we have - that's very much outlined in here. And you take through - it's step No. 2, safety when preparing to leave. And you do want to take some time with this. You at least want to get her thinking about this. You want to talk with her about what are the things that would be significant? Papers. Important papers. Um, sets of keys to cars and to the house. She wants to be able to get back in. She wants to have some money. She wants to have, um, anything that she might need for her children, her medical cards, any of those kinds of things that might be important.

She wants to always take the children with her. And so, maybe packing something that will be familiar to the child, that will soothe the child if they're out on the streets at 3:00 in the morning, if there's a particular stuffed toy or - or action figure, or whatever it might be. But have something that will be familiar to the child in that bag. Maybe one set of clothing for everybody

in case they get stuck really out there for a little bit. The things that she's going to need to be able to be - to make it and transition somewhat for a short period of time on the outside.

Now, where is she going to be able to keep this bag? That's gonna depend on her own situation. It may be that she can hide it adequately in her house and it may be that she has to hide it around her house. It may be that it goes to a friend's house who's willing to have that in their home and be available to her in that way. And that's stuff that you can help her think through.

Step 3, safety in your own residence. Now this is assuming that they have left and you have maintained the residence when you go through this piece. Changing locks, adding locks to windows, that sort of thing. And again, you're gonna involve neighbors in this. You know, like they're stalking, or if you can say to the neighbors, you know, I have a restraining order. He's been abusive; he's not allowed back on the premises. If you see that, you know, blue 1965 Datsun driving around, call the police. You know, because that's considered stalking, that's okay for them to do. You may want to warn if you see his car parked out front at any time, call the police. They don't even have to hear anything. That's a place again where, um, you can involve the neighbors in that way.

Safety with a protection order. You have an example of a protection order in your packet of materials. What I would say to you is that an important thing for you to do is to become familiar with what protection orders do in your particular state. Um, and you can use protection orders in your work site as well, so that if you as providers are feeling threatened, um, that is a mechanism that you have as well. But to become familiar with what is involved in a protection order for your state, so that as you advise her or you discuss this with her, you're able to tell her what it will and won't mean for her to protect her.

Safety on the job and in - and in the public. I know in the workplace, if you show the security guards, if there is one in your workplace, you are - your protection orders, then they know. And if you have included your workplace in that, then they will call the cops if - if the abuser shows up. So you, um, may name that. You may suggest to her that she names that as part of her protection order.

Again, if you think about this, you know, the first woman who talks about it. Is this embarrassing, or what? You know, I mean, think about this. You have to go to your neighbors. You have to go to your bosses. you have to go to the security guards at your job. But if you're really going to protect yourself, in a way, you have to out this behavior to pretty much everyone around you. It would be very humbling. It would be very humbling to think about having to go through that process, um, because again, you know - and part of that is just that we would walk around, ya know, feeling - I know I would walk around feeling like shamed, how did I get here, that now I'm having to tell everybody that I've got this guy in my life who does - you know? I mean, it's - really be a difficult thing to do.

There is additional steps in this booklet, "Safety and Drug or Alcohol Consumption," which talks primarily about - a little bit about what's she gonna do if he starts to use? What's she gonna do if she wants to use? How is she gonna protect herself? You know, and this can just be casual drinking. If she wants to be able to go to a party and have a couple glasses of wine, is that a safe thing for her to do, or does she need to set up mechanisms to protect herself if she in fact gives way and does that.

"Safety in my Emotional Health" is step 7 on here. And that other - that is a way of trying to help her to think about some, um, more empowering things to help herself. And again, we can't emphasize enough, you know, the emotional impact of the abuse no matter what form it takes.

And then the other things on here are items to take when leaving, a checklist of items, telephone numbers that she needs to know, and then a journal, um, which journals are really helpful to - for documentation purposes.

Now again, you know, very few people are going to go through this whole process, but it can help you to create something that's an abridged version. She might take pieces of it that she works on, pieces of it that you do in your clinical setting.

[Text on screen] Section III. Continues on Volume II.

[Text on screen] Questions and Answers.]

What is a safe haven for women?]

[Dan Sheridan] There's another safety plan that I do with every single woman that I work with, that I remind her what is open every day of the year, 24 hours, everyday, besides Denny's, 7-Eleven, and police stations?

[Class Participants] Hospital.

[Dan Sheridan] It's an emergency room. It's a hospital. And if she's wandering the street at 3:00 in the morning with her children and her safety bag - she's got it all and she doesn't know where else to go, walk into the emergency room and say help. Emergency rooms will not throw her out in the street. We have bought her at least a couple of hours of safety.

[Class Participant] And warmth.

[Dan Sheridan] And warmth. She's going to get the administrator on call, the social worker on call. Somebody's going to be there to deal with her and try to plug her into a system. We're not going to throw her back out on the street.

[What if the woman throws the first punch?]

[Dan Sheridan] The question that she said is is there any, uh, research or studies that show that the woman often will throw the first punch? What happens - and this was - when we talked about Walker's theory, that tension building phase, this was an explanation in that model, that she knows a beating is coming. She knows it's going to come, but oftentimes, she's going to want to control when the abuse occurs to be safer. She knows it's going to be coming. She knows his pattern. He has promised to hit her. So she'll often "trigger" the abusive episode in a - in a setting that is going to be safer in her mind than some other setting. She might do it when there's other witnesses around. She may do that when this month the phone is working, or this week the phone's working, because now if he beats her, she can get to the phone.

And it may not sound healthy from our point of view, but from her point of view, it's a survivor mechanism, that she may often trigger the violence. Now, some people will say, you know, some people have said, well, that's masochistic behavior. No, it's not masochistic behavior. It's survivor behavior. So she may actually push his buttons to get the - the violence over with. Now, the reason is because often after the violent episode, what does he do?

[Murmuring]

[Dan Sheridan] I'm sorry. I love you. I can't live without you. I - you know, I - if you don't - if you - if - if you hadn't have done that, I wouldn't have had to hit you, but I'm sorry that I hit you. Okay? But that there's that honeymoon phase. And this is where this guy turns into the man that she used to know, or this - this myth or this image that she's created. And this is for awhile that he becomes the nice guy.

You know, 90 percent of abusers are not violent outside the home. Are not violent outside the home. As we saw in the - in the training video here, these men are very successful lawyers, judges and - and police officers, and they coach the little league team, and they're ushers at church, and - and they're the minister at - at church. And to the rest of the world, these guys

have this Prince Charming affect. They come across as really nice, warm, caring, loving, great guys. And when they find out then that Joe beats his wife, they'll say to her, "Joe's such a nice guy. What did you do to tick him off?"

They just don't see this side of him in the home. This side of him in the home that can be caring and loving and good and kind. And - and she sees - she sees and she struggles with trying to capture and hold on to that good part of him. If this man was abusive 24 hours a day, every single minute, every single day, she'd be gone. She'd be gone. But he does - he - he uses this sort of split personality-type of thing, and that's really common with a lot of these guys.

[Why can't we ask, "why does she stay?"]

[Dan Sheridan] If I were to say to a rape survivor who came in for treatment, "Why were you out at 2:00 in the morning, why did you dress in that sort of an outfit, why did you accept a ride home from this man from the party and you only met him twice before and now he's raped you," what sort of statements would those be called?

[Murmuring]

[Dan Sheridan] Victim-blaming, sexist statements. Now, if I were - you know, if I say to a battered woman, "Why do you stay?", am I not holding her accountable for his violence?

[Murmuring]

[Dan Sheridan] See, what I love to do is I love to have men in the audience - and we have three men in the audience besides myself who are behind the cameras, and I'm going to invite you to join me as men saying to other men why do you abuse? Or I don't find that battered woman joke funny. When I heard that battered woman joke 21 years ago and laughed, I didn't know better, but today I do. When I hear battered women jokes today, I say to them it's not funny. Women die because of this abuse. Women carry lifelong scars because of this abuse. When I hear the sexist jokes now, I confront them.

I think the women's community has taken this issue tremendously far in a very brief period of time, but I think for it to really - to - to move forward even further, the "non-abusive" men in this country need to add their voices to the voices of women saying to men stop this behavior.

[Text on screen] Who "owns" the violence?

[Dan Sheridan] I mean, he - he owns the violence. And that's one of the things when they work with abuser treatment issues, they get him to - hopefully they get him to recognize that he owns the violence, that maybe she did do something that angered him and he maybe had a right to be angry, but his right to be angry doesn't justify him kicking her in the, you know, face 10 times, stabbing her, raping her, keeping her a prisoner in her home, that there's a difference between the right to be angry - because abusers are gonna be real quick to tell her, to tell you, to tell me, to tell the judge, "But she made me do it. It's her fault. She made me do it." No, she made you angry. You chose to be abusive. You chose to be abusive.

I mean, she'll carry with her forever - and that's the thing, that women often take ownership for his abuse, and that's what happens in the support groups, is that they try to get her to let go of the ownership of the abuse. And - and that's one of the things that can be really helpful in support groups, because women have - he's told her it's - "It's your fault, it's your fault, you made me do it." She begins to own that when she - it's - that's not hers to own.

And that's what support groups can be really helpful in doing, or individuals, or friends, or that's what you can do in your role as - as nurse-midwives, is help her to see - begin to see another voice that's saying to her, "You didn't deserve to be beaten. You don't own his violence. Yes, maybe you did tick him off. That's true. But you don't own the violence. You don't own the abuse."

[How does the United States compare to other countries for domestic abuse?]

[Pat Paluzzi] In terms of, um, industrialized countries, we ranked the highest.

[Dan Sheridan] We - we - we were the highest. We're also the highest in - in lethality, but the highest in homicide compared to any industrialized country, and that's because of the - the prevalence of guns.

[Pat Paluzzi] Handguns.

[Dan Sheridan] But - but one of the studies that have been done have looked at sort of the - the cross-cultural issues, and it does seem to be that in countries where women are struggling for equality, and it's more formalized, where women are breaking out of some of the stereotypical cultural roles, the violence goes up.

For example, right now there's a growing recognition of violence in Japan. Uh, Japan was thought to be a relatively non-violent-within-the-home society, and it probably was in the home, but it was really kept secret. But now, as Japanese women are trying to not fit into that traditional Japanese woman mold, the violence is going up. The violence is quite high in every industrialized country in the world.

The violence does not seem to be a major problem in - where women know their place. Women in the Middle Eastern countries, where women don't - "don't question" the rules and the norms. But again, getting into measure violence in those societies, and you're talking for the most part a lot of Middle Eastern societies, uh, it's kind of difficult because you can't even get in to do the studies without risking your life to get in there to do those sorts of studies.

[What can health care providers do as an adequate initial intervention?]

[Pat Paluzzi] If this is all that you can do because it's all she will allow you to do or all you have time to do is to ask the question, give her some pieces of information, validate her response, you've done a wonderful intervention; you've done a very appropriate intervention. And if it begins and ends there, but you put - move her on to other places where she can seek other kinds of help, that's okay.

[Text on screen] Section III: Intervention. Continued from Volume I. Pages 78-97.

[Pat Paluzzi] This is another way of looking at women as they make decisions about whether or not to leave or stay in one context, but it's really about the process of change. And there is another researcher in this field who has taken a model, which has been used, um, in order to look at diabetes and people's acceptance as they move through the process of diabetes and insulin injections and that sort of thing.

And she has taken that, and she has used it for women in abusive situations to look at how they go through different stages to change. And the nice piece about this is that she also then looks at stage-based interventions. So we're going to - we're going to label some stages, and then we're going to look at what are some of the interventions that would be appropriate during these different stages.

Now, I'm not saying to you that this is the way it is for all people. This is a model that we can look at. Stages of changes that she looks at. And she labels her stages as pre-contemplation, contemplation, preparation, action, and maintenance. And again, this is adapted from someone else's work on diabetes. But what she does is take and look at do - through the different stages what - what is this like for women in abusive situations? So, in the pre-contemplation stage, her image of the relationship is that most relationships are just like hers, and we've spoken a lot about that. So she accepts this as the norm.

As she moves through the contemplation stage, she might start noticing that in fact not all relationships look like this.

She comes along through preparation, that she begins to really maybe start to have some fantasies and some image and some vision of what a different relationship might be able to look like for her and that she might actually be worthy of, be able to have, whatever her thinking might be, a different sort of relationship.

Her action could be to learn different ways to be in the relationship.

And maintenance would be actually to be moving on into that relationship.

This is one of the handouts that you do have, so I'm not going to go through line-by-line and read the whole thing, just to give you an idea of how they've used this model to show how the woman will move through process.

And so she looks at this. Her - her issues are the image of the relationship, identity, control, context, definition and then options and alternatives -- moving from a cognitive to a behavioral. So, the second piece that we're going to do is just look at some of the - some of the quotes that she got when she did interviews. This is Jody Brown, who's doing this at University of Rhode Island. Some of the quotes that she's - she has that helps her to plug in to these different categories.

So going across the top line again, pre-contemplation. "I lied to cover up; I thought everyone else did, too." So remember, this is all relationships look like this. We all just pretend that they don't, is basically what she's saying.

Now she's starting to say, "Something's wrong. I don't know what to do, but this not quite right. This is not the norm."

In preparation she's needing reinforcement, she's needing to hear that people are okay.

Her action is beginning to own the thought, believe the thought that she deserves better than this.

And her - her maintenance is that her relationship with herself comes first.

And so you can on your own time again look through, go across and see. And I think what's helpful about this is that, um, I don't know that we have to buy all of these labels and - and stages, but sometimes it may be helpful when we're hearing women talk to kind of get where they are in the process. If they're saying, "Isn't this how it is for everybody?" obviously they have no - what you can do for them is to begin to talk about, no, this is not how it is for everybody and gently move them and understand that they're not ready to go all the way to - you know, to leap up to preparing for action and - and - and leaving. Just another kind of way to frame them. And we've talked about working with women, where they are in the process and not always trying to talk them into leaving. And Dan has said in different ways that, you know, one of the things that you can do, because it may make you feel better as well as make them feel better, is to really recognize all of the ways that women are taking them - taking care of themselves and have been within that situation all along.

You know, all the things that - the countless things that they have done to avoid being in a situation, to protect their children in a situation, I mean, whatever it might be, but they are constantly - as Dan said, they are survivors. They're constantly adapting and shifting and working to - to - to survive within this - within this relationship. And those are skills. And to acknowledge those and to help them to - to see all the movement that they are making so that neither you nor them see them as stuck.

And finally, she looks at stage-based programs, um, based on pre-contemplatives, contemplatives, preparation, action, and action maintenance. And I think that, you know, again when I look at this, I see ways that we as clinicians can - can have a piece all along this whole spectrum, you know, to - to help her to get - help to give her the tools that she needs as she makes her movement.

And also it helps a little bit then to know maybe what's most appropriate to offer to her. You know, if she's still in the pre-contemplative stage, you know, maybe what you're going to give her is a hotline number and just let her know, "You know, maybe you don't want this now, but maybe there'll come a time," and you give her a number, something like that, and you sort of drop it there.

And by the time she gets to the contemplator, you might be a little bit more, um, um, talkative about specific support groups that you know. Maybe you want to share with her where they're meeting, when they're meeting, a little bit more information, you know, sort of checking back with her the next time you see her, were you able to get there? How was that? You know, a little bit more along those lines. And on down the line. You kind of get the idea of how you can take them. If you can hear her quotes and hear where she's at and work with her from that point that your interventions can be more appropriate.

[Text on screen] Section III: Intervention. D: Documentation. Pages 101-104.

[Dan Sheridan] I want to talk right now about documentation. And before I start with documentation, I want to talk a little bit about my youngest son, Nicholas. Nick's nine. And a few months ago we were at Sears shopping, and I was getting ready - he knew I was getting ready to go out of town to, as I do a lot, give a lecture on domestic violence, and he knew I was going to be talking to a physician's group. And we're walking through Sears and he says, "Dad, you have to buy this tie. You have to buy this tie."

[Laughter]

[Dan Sheridan] And I'm going, "Nick, why do I have to buy this tie with Bugs Bunny on it?" He says, "Well, because up - up - you're up in front of the docs and you don't know what to say, you kind of lose your point, you could say, 'Hey, what's up, doc?'"

[Laughter]

[Dan Sheridan] And I said, "Nick, that's great."

[Class Participant] Good.

[Laughter]

[Dan Sheridan] That's good. It was good. But then I looked closer at the tie, and here is Bugs contemplating musical notes. And see, and I want you to contemplate not the musical notes, your progress notes, your medical notes.

[Laughter]

[Class Participant] Ha-ha.

[Dan Sheridan] Okay? I want you to think about what you're writing or not writing in that medical record.

I do a lot of talking and consulting on this whole issue, and if I had a quarter for every time I read a health provider's documentation that says, for example, 27-year-old white female, multiple head trauma, hit by hammer, 22-year-old black female, multiple back trauma, kicked by foot - I read these all over the country. All over the country. I picture there must be some hammers or feet that just randomly float around up in the clouds and just say, "Ha, you're next."

[Murmuring]

[Dan Sheridan] That documentation is worthless documentation. I want you to write patient states her husband Daniel J. Sheridan, Social Security number - date of birth - struck her at 9:00 p.m. yesterday evening, at the corner of 4th and Main Street, witnessed by her two children Mary and John. There is no ambivalence who hit her. I cannot sue you for writing that. Patient said. Patient states. Preferably, and especially if it's a juicy quote, write it verbatim. Verbatim. It is worthless to write, "Patient states that her boyfriend beat her up last night." Good defense

attorney is going to say, "But she had three boyfriends last month. How do we know it was this boyfriend that beat her up?" I want you to write that patient states that her boyfriend Jimmy Jones III, Oregon driver's license no, Social Security - women know these numbers, by the way. They do. You know, guys, we have that Y chromosome. Used to be an X. The part that fell off is the part that remembers numbers and fills out forms.

[Laughter]

[Dan Sheridan] Women fill out forms, remember these numbers. They know his Social Security number. They know his date of birth. And she knows his driver's license number. She knows this stuff. And if she doesn't have it up here, she's got it in her purse. Write it down. There is no ambivalence.

As you saw earlier when we showed the injury slides, I used that '-like.' If she has injuries, then I'll often, especially if they're patterned injuries, I will use that cord-like, whip-like, punch-like, slap-like. If - if you can - if you can make that connection, it's real important that you document that. That's in the objective part.

Now, my subjective entries can be quite extensive. Often when I've been called in, I'm being called in as the consultant. I have the luxury of being able to spend maybe 25, 35, 45 minutes uninterrupted with that woman. You may not have that luxury. So, your subjective entries may not be as detailed as mine because I'm coming in with that luxury, but I want you to write down what she's telling you. She's told you a lot in that brief period of time. She's told you a whole bunch.

Paraphrase it. Patient states, patient said. Do not use patient alleges. Avoid that word "alleges." Allege is - told to me by a lot of prosecuting attorneys is that when that word "alleges" is read into the chart or read into the court, somehow jurors think "alleges" means that she lies. That if Pat allegedly did something, that she - it's something bad. Alleged has this negative connotation to it. If she, you know, alleges that her husband - then she's lying. So avoid that word "alleges." Use "said," "reports," "report," "said." Once in awhile I'll say, "per history," because I get tired of saying - you know, but per her history. Now, again, my objective is I'm - I'm - I'm saying what I'm seeing. Are there injuries there? I'll measure them. Not only have I tried to photograph them, but I've also, you know, given a good detailed description of what she has. I'm also in my objective describing is she tearful while she's talking? Is her affect blunted? Is her affect not blunted? Ya know, so sort of that what - is she a good historian? Is her speech clear? All of those sorts of things.

Do not write ever in my chart - if I'm seeing you; and I probably wouldn't be seeing most of you nurse-midwives, but if I would see a nurse practitioner and you wrote in there, "Positive EtOH on breath," what does that mean? How many people have written that at some point in their career? Positive EtOH on breath. That is pejorative, meaning opinionated, documentation. Because someone has an odor of alcohol does not mean that they've drunk alcohol at all. But we - we write that all the time.

You better not darn well write positive EtOH on my breath if I'm in as a patient unless you're now going to draw a blood alcohol. And because I'm coming in because I sprained my ankle, there shouldn't even be a need for blood alcohol if I'm alert, I'm cooperative, it's fine. You know, maybe I did have a beer, but it has nothing to do with the fact that I sprained my ankle. Unless I'm slurring my words and I'm - I'm stumbling or I had head injury, then it has significance. But we write this all the time with battered women. We write battered women, positive EtOH on breath, and now in a child custody battle two years later, she's an alcoholic, Your Honor. She got those injuries because she was drunk. And see, the - the - the ER says positive EtOH on her

breath. It's pejorative documentation. And yet we do that all the time. We do that all the time with our patients. And I caution you on that. You're going to get turned around and sued one of these days by someone for writing that.

If there's a need, if she has behavioral changes, she has head injury, she's not cooperative, that alcohol might be interfering. Um, and if you think that she is drinking and she's pregnant, well, then you're going to draw serum alcohol. You're going to draw - draw serum alcohol. Okay? Now, so that you - you can't have one without the other. So you can - you can say positive EtOH, but then you'd better have some reason then why you're now ordering the serum alcohol level. Okay.

My assessments. I often will write "per history." This woman's been involved in a 10-year relationship with her husband, Dan. Per history it's been escalating in violence, or it's not been escalating in violence per her history. I use a lot of "per history."

I will at that point be documenting whether her history is consistent with her injuries, whether her history is consistent with her affect. Okay. That's my assessment. I will not write patient is, um, married to a wife abuser. It's - it's up to a court to decide that. It's up to a court to decide that.

I will say per history, she's been involved in this ongoing escalating abusive relationship. Okay? But I don't know for sure. I can't say that she is - you know, only if he is convicted of - of wife abuse, of sort of an assault or battery can I say that. But at this point I'm saying per her history. And I'll use the word "is consistent with," or it's "not consistent," or I'll use, um, her behaviors are congruent; that word "congruent," or not congruent or incongruent with. And so I'll - those are those are sort of the words that I use: "consistent," "non-consistent," "congruent," "incongruent."

My plan, what - what do - what do we - what's the plan then, and what's the safety plan that I'm working up with her? The plan is that she's choosing - choosing - use that word "choose" - choosing to go back into the abusive home. I often will read, "Patient refuses to talk to the police." Your attitude is coming through real clear right there. When you say she's refusing to do something, the assumption is that a reasonable person should.

I smoked for 20 years. Okay? Okay. So I refused to quit? No, I was choosing to smoke. And it was a dumb choice, but I'm entitled to make dumb choices.

So if she's choosing to return to that abusive home, I may not think it's the safest choice for her, but it's her choice to make. When we use that word "refuses," that is again pejorative documentation. Pejorative documentation. She's choosing to not talk to the police. She's choosing to return to the abusive home. Uh, you know, reviewed multiple options with her. At this point all shelters are full.

Safety plan - so, I - you know, what are we doing? Safety plan, she's going back into the home. Safety planning was conducted with patient on how to more effectively use 911. Okay? I'll write in there, safety plan, how to more effectively use 911.

Safety planning given on how to pre-pack an emergency flight bag. Okay? Patient reminded that emergency rooms are open 24 hours a day. Can - can - can - can return for safety reasons. Plan is she's going to her sister's. See, a lot of times the shelters are full, but as Pat said earlier, we need to review her other options.

Women often - I'll ask her before, "Well, where have you gone in the past to be safe?" That's one of my questions. Where have you gone in the past to be safe? And women will say, "Well, last year I went to my friend Kathy's house, but I don't want to impose on Kathy now. You know, she's got a new baby and, you know, I - maybe her relationship with, you know, her husband's

not too" - and I'll say, "Why don't you call Kathy and let Kathy be the judge of whether it would be an imposition for you to go there tonight?" Okay? She doesn't want to impose herself on someone. Why don't you call?

Now, I don't make the phone calls for her. Even though, as we said, you know, Marge's hotline grew into a shelter, and she was the "executive director" of the shelter. When I was in Chicago and I'm in the ER at Rush and I would call to the shelter -- the fact that I was married to their boss didn't make any difference. If they were full, they were full. Okay? But the fact is: I don't make the call to the shelter. The woman makes the call. The shelter doesn't want to talk to you. They don't want to talk to me. They don't want to talk to Pat. They want to talk to the woman. So I will facilitate her having access to the phone, but I'm not the one that makes the call for her. She's got to make that call for herself. Otherwise, I may do all this work "for her," and "to her" - again, it gets into that victim versus survivor role. If shelter is something she's serious about, she will make the call. I will be right there with her. I'll dial the number and hand her the phone. She's got to talk to the shelter staff. The shelter staff want to talk to her. They don't want to talk to me. Okay?

Now, once the shelter and her both agree that there is room and she can get in, I may have to get on the phone with the shelter staff to do some of that systems coordinating on how to get her there - on how to get her there.

Documentation is real important also in finding creative ways to get women admitted to the hospital. Now, one of the easiest ways to get women to admit it if they've been hit to the head is rule out closed head injury. As we heard earlier, if you were in a motor vehicle accident and banged your head a little bit, you may get an overnight admission, rule out closed head injury, or rule out multi-system trauma. And we're going to draw serial crits on her and all sorts of - you know, see?

But we - a lot of these women get some pretty profound beatings. The woman that we saw in the video, the woman from my slides, a lot of those head injuries, that's pretty significant head injuries. We can get her an overnight admission, rule out closed head injury, rule out multi-system trauma.

Or why not use -- write this number down -- 995.81, adult maltreatment syndrome. Who here knows the correct acronym for the ICD-9-CM, ICM-9 - what is - anybody know, the International Code of -

[Class Participant] Classification.

[Murmuring]

[Dan Sheridan] - Classification of diseases, you know, the - the - the diagnosis bible. This the number out of that bible, 995.81, adult maltreatment syndrome. And my understanding from physicians who admit under this and from billing departments is you can get about - you can get an overnight admission with this diagnosis, paid for by Medicaid/Medicare. Simply on that diagnosis alone.

Now, it - it's interesting thing, that same bible, the E Codes, the injury codes in this diagnostic bible, they have injury codes that if I were to be injured in a thermonuclear explosion, they have an E Code for that.

[Laughter]

[Dan Sheridan] If I were to be injured by an anti-personnel missile, there's an injury code for that in this diagnostic bible. Now, the likely of that happening is pretty remote, but there's an injury code for it. There is no injury code for battered women in this diagnostic bible, but they do have this disease code. And it's - it's classified under "Other". They had nowhere else to put it, so they

had this section called "Other". That's where - that's where it's - can be found. It's a very obscure code. But if you make that as a diagnosis, then the billing department tracks these. These numbers are - then if there's injuries, are reported to state health departments, and it does help sort of in the quantification of this as a major problem.

But the documentation issues is every woman that I work with, I remind her that the chart that I'm writing in is not my chart; it's her chart and that she has access to it. And I also tell most women, probably not every woman, but I try to tell most women that I work with before I talk to her that I intend to put a summary of what we talk about in her medical record. If a woman says to me, "I don't want - I'm not - you know, I - I want you to promise you won't write any of this down," I don't make that promise. I don't make - I don't get caught into that bind where I've made this promise and now I have to do it.

I let her know that I'm going to be writing a summary of it in there, and that even before we talk, if she shares something with me that triggers my response to call the child abuse hotline, I have to do that. Okay? I try to set that up ahead of time, so that she knows as she's talking to me, that I may have to at some point announce that I'm going to need to call the child abuse hotline.

And I've never called the hotline behind people's backs. If there is a need, I will let her know why I have a need to call the hotline. And, in fact, I often will invite her to call the hotline with me. Usually it's not because of her abuse, but because the children are being hurt or they are at risk by this guy that I have no doubt - I have no choice but to make this call. And I'll say, "Why don't we make this call together?" And I've had a few women say to me, "Well, you're making me choose between my kids and my husband." And - and I'll say, "Yes, I am; yes, I am."

Most women will choose their kids over their abuser. The women that tend to choose their abusers over their kids are women who I have found who have alcohol and drug problems, and their choosing their substance abuse over their children. Now, there are some women out there, I've worked with a few, and somebody brought this up at one of the breaks, said there are some women out there who don't want their children. Yes, some women don't want to be mothers. You know, we - society sells this thing that, women, you've had a baby. Now of course you want to mother this baby that you just had. I mean, don't -- biologically and genetically you have to want to mother this baby.

And I think sometimes we have to give women permission to be able to say this mother thing isn't for me. Yes, I am the mother of this child, but I don't want the child. And so you to be - that has to be one of the "antennae" you have out there is trying to assess. There may not even be abuse going on. It may be just she doesn't want to have this child as part of her responsibilities. And that could be true for younger women and not so younger women. So I think we have to keep that as an option.

I let women know that the chart is subpoena-able, and under court subpoena that chart will be introduced into court and it can be used to her benefit, more often than not, used to her benefit. So I think that the charting is a very important issue. It gets pretty detailed. What we do with the charts that are photograph - with photographs in them, they are not stored in the regular medical records department.

What we found, human nature being what it is, I will have this whole series of really graphic ugly pictures in there, and the medical records technicians were sort of like, ooh, come on over here and look at this, and they ooh and ah over it. These charts with the photos in it go into the, either the "VIP" or the legal file that only a supervisor, medical records supervisor has access to that area.

Okay? So they're given directly to the -- these pictures are given directly to the medical records supervisor, and that only people with - even though we're a teaching hospital, only people with a "need to know," need to access that chart are given that chart.

This chart is - you know, most teaching hospitals, anybody who's a student can request any chart for any reason and, you know - but these charts you really have to be able to show why do you want this chart. You have to go through a supervisor in order to get it. So then again, it helps to give her a little bit additional confidentiality, as far as what she has shared and what we have photographed.

Now, if you don't document it - let's say she's been into the clinic six times, and six times you've heard quite of bit, you do minimal documentation, you do protective - you're trying to protect her by not documenting. And then a week after that last visit, she either gets killed or she blows him away. Now, it's premeditated murder. Where is her paper trail that she's been in this abusive relationship?

You, which were her nurse, you had just - you - now you're gone. You've retired. You've moved 1,000 miles away. They can't track you down. The new persons says, I only met her once and she didn't talk to me about abuse, or the only thing I know about her is in their medical record, and there's not much here.

I think we do her a disservice by not charting. If her records are not confidential, that's a systems problem, not her problem. Again, we're holding her accountable for the fact that we can't keep our medical records and our staff quiet. We need to fix our medical record storage system and we need to impress upon our employees that what you read is confidential. And if somehow I hear you talking about so-and-so out in the public area, you're fired. Gone. Bye.

[Pat Paluzzi] You can also separate pieces, though. So if you're not doing the whole forensic piece with pictures, and this is not a clear case, but there - she has perhaps outed the situation to you, you have made copious notes, she doesn't want that included in her main chart, you can separate pieces of chart, just as people can do that, therapists can do that. And then that can't be accessed in the same way. Like when somebody pulls her records, they're not going to get all of that. That has to be accessed then a little bit differently.

So, if you're doing more of, like a chart documentation piece and don't want it to be part of the main chart, you can separate that. You could do it in your own office setting as well. You can have a separate locked space where those go, so that your secretaries and your receptionists and everybody else aren't reading those notes. There is a - you can do it, even if you're trying to protect some of like her disclosure to you, in that kind of way.

[Dan Sheridan] We have a system through our university where all film goes out to a private developer. It's not taken to Kmart. You know, we don't take it into - into Costco or any of these places where they can be developed, you know, cheaper. We pay more. But there - that does actually maintain chain of evidence, because it's where all film out of that hospital always goes. You may have to have a system, if you use 35 millimeter, where you personally take it to one of these as-you-wait-they'll-develop-it-type things. And it costs more money.

I use 12-exposure color film. The using - reason I use 12 is it's only one patient per roll. The first photo that I always take is a picture of the consent to photograph form. I take a picture of that first, because that also tells me if I can use these photos for teaching slides, if I can make them into slides later, because she's checked a box whether I can use them as teaching slides or not. The second photo that I take is a direct sort of full facial or full body shot. And then I'll narrow in on the actual injuries by taking a series of shots. Most patients, 12 exposures is usually plenty to

photograph all of the injuries that she has. If a woman has multi-system trauma, I use a second roll, or a third roll. Okay? But most often it's just one roll.

And then I immediately send it out, and have arranged ahead of time with her where is a safe place to send the developed film? Sometimes I just store it, and if she ever needs it, it's there in her medical record. It's there in her medical record.

[Class Participant] So you don't always keep those pictures that you take, or do you?

[Dan Sheridan] One copy gets taped into her medical record. On the back of each copy - I have a little macro set up in my WordPerfect where I just have to fill in - you know, patient name's already there, patient ID number, patient date of birth, photographer's name. And I type into the WordPerfect, you know, her name, her date of birth, the date that it was taken. I print out these labels on the Avery labels and I slap that on the back of her photo. And then I - the one set gets taped to her medical record. Okay?

Now if it ever gets dislodged, the tape gets old, wears off in the medical record, then - and the back of it has her, you know, name and all that. And then the second set, the duplicate set is the set that's either given to her or given to the court system or to the police with her permission.

Okay?

I invite many women to come back a second time for a second set of photos, because sometimes the next day or two days later they look much uglier than they did the first day, and that has sort of a dramatic effect when they're introduced in court. So if she's willing to come back for a second set of photos, I'm willing to take them. Okay? Not a problem. I can do that.

But I think Polaroids are fine. Not everybody is comfortable using a 35 millimeter camera. And the one thing that I have learned the hard way is sometimes you're trying to take these pictures in less than ideal lighting situations, and you get these spotlights that we often use, the goose neck lamps or the spotlights. And you shine that onto the wound and then you use your flash. And you take another picture and you end up with nothing - what they call burnt. It is just - ya know, the picture is just burnt. It's too much light.

It's better to use less light and more flash than it is -- or use a lot of light and no flash. I kind of learned that the hard way. What I thought were great pictures and I'd get them developed and it's just nothing.

What I have heard repeatedly, and what I have found through my experience is the more detailed my documentation is, the more in-depth that it is, the less - the less likely it is that I actually have to physically ever appear in court. As my documentation has gotten more thorough over the years, my subpoena rate's the same. I get subpoenaed on quite a few, but quite often two, three days beforehand they call me up and say we have an out-of-court settlement. Okay?

Because usually what happens is the defense attorneys, especially if it's a public defender, don't really get copies of these cases until maybe two days before it goes to trial, or maybe that morning. And they read through this stuff and they see all this documentation. They go, oh my God, my client's going to get burnt. Okay? So they'll convince him to wheel and deal.

I used to get very, you know, kind of anxious. Every time you get a subpoena, oh my God, a subpoena. I'm going to go to court, you know? And now I get it, I just - you know, great. I just make sure my calendar's blocked out. But knowing that almost every single one of them, at this point, because of the thorough documentation, they do out of court - they do pretrial settlements. You're more likely to get subpoenaed and have to appear in court for not writing, at this point, in domestic violence areas than you are for writing a detailed summary. Especially if you're using excited utterances, especially if she's coming in, and she's crying, and she's upset and she was just hurt, and you're writing this down and her affect - and this is an excited utterance that's all - that's not hearsay. That's admissible in court.

[Text on screen] End Section III: Intervention

Begin Section IV: Resources and Referrals. Pages 111-138 in the manual.]

Section IV: Resources and Referrals. A: Legal Aspects. Pages 113-127.]

[Dan Sheridan] What is the difference between a protective order and a restraining order? And we use them interchangeably because depending what state you're in that's what they're called. In Oregon they're called restraining orders. In the State of Washington they're protective orders. In Illinois they're orders of protection.

But in essence they are civil court remedies. She goes to a civil court and gets a court remedy that can say one of many things. This court order is usually - all of these orders are usually part of some domestic violence legislation. Every state now has some sort of a protective order or restraining order. They're the same. They're just called different things, but they can offer a lot of the same remedies in every state.

They can tell him, the abuser - now if he's being abused, he can go get one, too, but I'm gonna talk to it as if he's the abuser and she's, in the criminal term, the "victim" of the crime. That basically tells him to back off. It may order him out of his home. He may still be required to make mortgage payments, but he may be ordered out of his home. It can give her temporary custody of the children.

It can order him not to come within 500 feet of the school of where she's going to school, or her workplace. It can order him to pay any out-of-pocket expenses that she may have. It may be able to order him to pay any medical costs that she may have incurred because of his alleged abuse. Restraining orders or orders of protection are not valid until he is served. The fact that the woman is able to get these relatively easy - it's now 3:30. It's probably a bit late, but Monday through Friday, right down the street, 4th and Main, right across the river, you can go into the Multnomah County courthouse and with no money - they're free here, not all states are free. Not all states are free. Okay?

But you can for pauper's petitions. Okay? If she has no money, she can still get one under a pauper's petition. But they're "relatively" inexpensive, and in many communities they're free, but not all.

But she can get these orders that the judge will issue probably the same day that she goes. She's got to fill out forms. But they're not valid until he's serviced. Now, who can serve these orders? Often these orders are given to a sheriff or some - you know, some how a law enforcement agency goes out and tries to find this guy and serves him, but I have served dozens, dozens of restraining orders throughout my career.

How we've done it is he's been come - she's hospitalized now, often because of his abuse, or complications of his abuse. She's hospitalized. I have gone on behalf of women who can't go to court, because I've done this ahead of time. I've prearranged with the judge. What if we have, you know, what if, judge, we have someone who's beaten up, they're hospitalized, they're eligible for these orders, but they can't get to court? And then I've arranged and I've gone on behalf of them.

We - she fills out the paperwork at the hospital. They're notarized in the hospital. I go on her behalf. We get the restraining order. He shows up to visit. I've coordinated that security is nearby. Okay? And I say, excuse me, sir. You are now served with a restraining order and we have named the hospital in the restraining order, and he can't come up to visit her. Any competent adult can serve him that restraining order.

There's an additional form I have to fill out, and that's true in every state. There's an additional form you have to fill out, and it has to be notarized and sent in to an appropriate address. But you

could serve someone. Now, if I'm - if you're - you can't serve me with your own order, but your adult sister could, your brother could, your mother could, the next door neighbor can. Okay? Now, what's good about these orders, that they're civil orders, but if I violate the order, in almost every single state that violation is now a criminal offense.

Let's run a scenario by. Let's say Pat and I are in an intimate relationship. She gets a restraining order because she told the judge that I beat her up. Okay? She may not have had me arrested for that first assault, or battery, but she's not got the order. I've been served. I - you know, I meet her on the street. I have violated that I'm not to come within 500 feet of her, and I hit her again. I've now committed two crimes. I have violated the restraining order and I've hit her again.

Now, I'll give you a guess, which criminal crime - which crime am I more likely to do some jail time for, hitting her or violating the judge's order?

[Audience answers]

[Dan Sheridan] I have bruised a judge's ego by violating that order. Okay? And so, yeah, it has some teeth to it. Restraining orders, orders of protection, I think are essential that every woman knows about. They are helpful for millions of women around this country.

But every woman that I talked to about a restraining order and order of protection I will say these words: this order of protection is not bulletproof, it is not knife-proof, and it is not punch-proof.

What do you think - how is he going to respond when he is served with this order? Do you think you're going to be an increased - she's going to say he's going to be angry. Okay?

Definitely he's going to be angry. But what's he going to do with that anger? Is he going to hurt you more because of it? Is she at risk? And some women have said he spent seven years in jail for manslaughter. He doesn't care about any restraining order.

I may not prioritize getting her a restraining order that day. I may find some other things for safety issues. But I think restraining orders are helpful. But most women who are killed are killed in the process of leaving. Many of these women have restraining orders. What happens when she lets him in? Now, I want to rephrase that. No, he chose to violate the order. A lot of police officers will say to a woman, Ma'am, you have invalidated this order by inviting him back in. I'll use Pat, again, as an example. Pat and I are in a relationship and it's our son's birthday. Okay? Now, I got this restraining order that says I can't come over, right? But she invites me over. Well, it's your son's birthday. Let's just pretend you don't have this restraining order. Come on over. I want you over. She's invited me over.

I come over and sometime during our son's birthday party, I hit her. Cops are called and the cops say, well, lady, you invited him back in. You vacated, you violated this order. No, she didn't. A judge issued it. She doesn't have the power to invite - to - she can invite me over, but she doesn't have the power to violate the order, to vacate it. Only a judge - the legal term is vacate. Only a judge can vacate that order.

What you can do as nurses, as advocates, is if then the police - she's there in front of you because she got beat up or she's hurt and the police are giving her grief, you can advocate for her, saying excuse me, officer, that she didn't violate the order. He violated the order. She didn't vacate it. He chose to come over. Only a judge - once the judge issues the order, only a judge can take the order away. Only the judge can.

Now, what will often happen is, under mandatory arrest he should be immediately arrested. If she has a pattern of inviting him over and he has this pattern of coming over, at some point the judge should be saying to her, ma'am, I issued this order because you convinced me that you were in danger. Are you still in danger? You keep inviting him over. Are you still in danger? Do you still need this order?

Some judges have then vacated the order, and some judges have said to her, ma'am, I have issued this order and I'm not going to vacate it. If you invite him over again, I will send you to jail for contempt of court. I think you're in danger. Okay? So again, the judge has the power to - to vacate these orders, not her. She doesn't violate it by inviting him over.

If I'm served with a restraining order, in most states I have the choice to request within 30 days a hearing so I can present to the judge my side of the story before a permanent one is issued.

Okay? If I'm served and I choose not to show up in court or ask for a court date, that temporary order often converts into a permanent order. So there is a due process for me. There is an opportunity for due process for me so that I can contest these restraining orders. So that way my constitutional rights would not be violated.

[Text on screen] Section IV: Resources and Referrals. B: Advocacy and Activism. Pages 128-136.

[Pat Paluzzi] Part of the project, the goals of this project is very much to address the issues of advocacy and activism. Because again, going back to what we said in the very beginning of this talk this morning, this is a public health issue. This is a community problem. This issue is a problem that requires a a public health, a community response. It is a multidisciplinary problem. It is not one person's problem.

So, how do we do that? We have to do that by forming multidisciplinary teams. We have to do that by knowing our community resources. We have to do that by being actively involved and by being able to know the things that we need to know to correctly advocate for the women that we're taking care of.

What we can tell you is that in 1992, I think it was, JCAHO mandated that each hospital has to have certain things in place to deal with the issue of domestic violence. They have to have a set of protocols and they have to have - emergency room personnel have to be trained. This is now currently being expanded to include ambulatory personnel have to be trained. There have to be resources within this hospital community who are able to advocate for and deal with people who are involved in abusive situation.

So the very first thing that we can all do to advocate is to go back to our facilities and to find out if in - what in fact have they done. Did they create a little binder that is their protocols and put it aside, and that was the beginning and the end of how they met JCAHO regulations?

Is there a multidisciplinary team that exists within our hospital setting? If not, why isn't there and do - would we like to be the ones to agitate for that to begin? Would we like to be a part of that team, if it already does exist? Is there - what kind of nursing or midwifery or mid-level provider representation is on this team? Who is on this team? And would we like to be a part of that team?

And it's a very good place to begin, because it's completely legitimate. They have to come up with the resources. You don't have to go out and fundraise or anything else before you can do this. They're supposed to be doing it. You can just go and hold them accountable for it, become involved in the process of seeing that it gets developed or join with what already exists and go from there.

Okay. Okay. So then what that will do for you within your hospital setting is you'll know what your referral sources are when it goes back to referring. In the community setting you are gonna have to go back to your communities and you are gonna have to find out what's going on there if you really want to do a good job of providing care.

Because when the woman says to you, you want to be able to tell her if there are any shelters in your community where they're located. You know, if there are any hotlines, what's the number of the hotline?

You know, if you know if she is somebody who would like some sort of therapeutic counseling for whatever reason, maybe because she feels like this would be a useful thing to her, you want to know the names of therapists who are gonna understand her situation and counsel her appropriately within the context of domestic abuse and are not going to look at her, you know, her fault and do all of this sort of victim-blaming stuff that we've talked about, which is easy to do if someone is not, you know, looking at it from the proper framework. So you wanna know the people that you refer her to, that they're gonna be appropriate in their response to her. If she needs drug treatment, again who can you send her to that's also gonna understand that the abuse is a whole separate situation and it needs to be dealt - it can be questioned, it can be talked about, but it needs a separate set of services in order to deal with her abusive situation separate from her drug abuse or alcohol abuse.

So you - you do have to go back into your communities. One of the things that you have in your packets of materials are your state domestic violence coalition numbers. Some are gonna not be current, but hopefully there'll be something that will tell you to where go - you know, where to go next. Probably the names won't be current. The phone number should be the same.

I would think that the players would change, but I would think the phone numbers would not. Those are a place where you can start. You can find out from those folks within your state what kinda services are available and where you can begin to find out about the services. So that's a good place to begin. You have some other resources. Family Violence Prevention Fund. They're like a clearing house for medical-related information. They can tell you who's written what protocols, that sort of thing. Again, don't forget that ACNM is here to help out with any kinda resources.

The Violence Against Women Act was signed into law by President Clinton, and with it was - came a lot of money allocated to do several things, which was to vastly increase the services across the country for shelters and hotlines and resource centers and all kinds of different things. That just came out in about the past week. What he also did a part of that was developed a Violence Against Women's Office and named Bonnie Campbell the director of that office. And so, on a national level, the President has taken charge to call - to name this as an agenda item for his administration that requires national attention.

In the activism thing, what can you do? Well, you can do as much as you wanna do, obviously. Nobody would say to slow down. But at the very least what you can do is watch for stuff like this. Now that you've had your consciousness raised, when you see - like you see something in the paper about insurance companies who are now not going to, you know, offer life insurance for people with this history, you write letters.

You know, you start lobbying. You make phone calls. Just raise your consciousness a little bit, crank it up a little bit and talk. You know, be writing to your senators and your representatives, if you do nothing else. Those things are really important. They make change. If they get four or five letters I'm told they think that this is a significant thing. So, you know, be one of the four or five that writes them a letter.

[Text on screen] End Section IV: Resources and Referrals.

Begin Section V: Taking Care of Ourselves as Providers. Pages 139-146 in the manual.

Section IV: Taking Care of our Ourselves. A: Maintaining Safety and Support. Page 139.

[Dan Sheridan] I have the luxury, or have had the luxury in the roles that I've had within the health care system to most of my interventions within a hospital, a teaching hospital setting where there are security guards. And in Chicago the security guards carry guns. In Oregon they don't, but there are still security guards, and they've had a little bit of training and they carry, you know, these wands and sticks and they - you know, they have handcuffs.

And one of the things I do to take care of myself is I make it a point never to confront an abuser unless I absolutely have to, even if women have said to me, can you go out there in the waiting room and tell my husband to not hit me anymore. And I can say to her, ma'am, yes, I can tell him that, but let's review how is he going to feel when he finds out that I now know what he's doing to you? How's that going to put you at risk? So, doing some of that reality checking.

And then I try to say to her, ma'am, I can tell him that, but unless he's motivated to stop his behaviors, I don't have the power to change him, to change his behaviors any more than he has the power to change mine, or I have the power to change yours. You've got to make these choices for yourself.

There have been times when he's out in the waiting room and she's ready and wanting the police involved. And in this particular state there's not mandatory reporting, but now she wants the police involved. We have a safety plan all lined up. We know where she's going to go for the next umpteen days to keep her safe. We've got the police. And the police come and I go out there with security and say, excuse me, sir, you know, the security's here and the police are here and you're going to jail.

[Laughter]

[Dan Sheridan] Now I've had a lot of abusers then get really huffy. They get red in the face. You could just see the rage building. You can see the rage building. But they keep it under control. They keep it under control. Okay? And I've actually said to some abusers I can see how angry that you are right now. I can see how angry you are, but you won't hit me because you know a couple things will happen.

I most likely will hit you back, sir. But see the security officer behind me and the police officer down the hall? They're more than happy to arrest you for hitting me, in addition for the abuse that you did against your wife. So again, he's able to keep control in that situation. He's able to keep control.

I also, though, have an unlisted phone number, which can be a little bit difficult when people try to get a hold of me from around the country and I have an unlisted number, but if they get my voicemail, I tell people how to beep me and they beep me all the time. But there's a reason why, and that's because I've had abusers who I've helped put away in jail for a long time.

They're now spending 3, 5, 7, 10 years in prison and I've been a great help in that process by my documentation, my photographs and my testimony in court when he is sitting less than five feet away from me as I swear to - you know, to tell the truth, nothing but the truth, so help me God. And I'm helping to put him jail. So, while I bet most of the time family violence stays in the family, I don't necessarily want to be a martyr for the cause.

Anybody who's worked in domestic violence for awhile has lost women, has lost clients to the abuse, and it's really hard. You have to revisit it. And, you know, you - you also have to be very careful not to take it home. Now, luckily Marge is a social worker, and a damn good one. And there've been quite a few times that I'm sitting at the kitchen table and I'm just - I'm talking about my day, right? Okay? And she goes, Dan, you brought another woman home.

[Laughter]

[Dan Sheridan] And the minute she says that, I know exactly what she's talking about at this point and I said, oh, I have, huh? And then she'll say what is it about her? What is it about this woman that you have this need to rescue her, to fix her more so than the scores of others that you've worked with? Because then there's usually something about that woman that is triggering in me that fix-it. What is it about her that I'm bringing her home with me to fix her. Okay?

And then I have to step back and I need to revisit to take care of myself. Because to keep my sanity I can't bring these women home. Sometimes if you have to do advocacy and interventions, you have to do it at, you know, at 7:00 at night. That's different than bringing her home with you. Sometimes your advocacy requires you to do work in the evening, because sometimes systems don't work from 9:00 to 5:00. You gotta get a hold of them at 8:00. Okay?

That's different than bringing her home on an emotional - on an emotional level. And so, it's real helpful for me to be married to that social worker who can remind me when I'm trying to fix her. Okay?

And then I also try to set up ongoing clinical supervision so that I can sit there and on a selective basis I can go through cases and then I can talk about I've had these sorts of cases. This is what I did. And to have someone who's sort of objective and not a part of it saying, well, that was pretty good, but did you - you know, did you think about what could you have said here? That sort of clinical supervision can be real helpful.

You need a place that you can feel safe. You need a place where you can sit there and you can vent and you can scream and you can yell, and you can say the only good abuser is a dead abuser, and feel safe to say that. Even though that's really not what you believe in your heart of hearts, but at that point in time it just feels like that that's the only thing - the only option you had available. You need a place to say that safety. Boy, I just said this and there's cameras rolling.

[Laughter]

[Dan Sheridan] But I'm just using that as an example, if that's how you felt. If that's how you felt.

[Laughter]

[Dan Sheridan] You need - hypothetically you need a safe place in order to say that. Okay? And that's not something that you can say in front of everybody and feel that it's okay, but you gotta have a safe place where you can vent your own anger, you can vent your own frustrations, you can basically say the system sucks. And it does, but it sucks a hell of a lot less today than it did 20 years ago. Okay? We gotta long way to go. So you need those sorts of safety systems.

[Text on screen] Section V: Taking Care of Ourselves. B: Preventing Burnout. Page 139.

[Pat Paluzzi] I want to just talk a little bit about, you know, burnout in this and what - how to look at this perhaps when you're doing this. And I think there's a lot of you in the room who are already doing this to some extent and may be further on down the road than others.

I think, you know, we, and we've hit on a couple of things, so this is just sort of a final summation of this. We've talked about, you know, what can you do and having sort of your perspective as a provider, not - wanting to fix, knowing you can't fix, all of those kinds of things. And I think that, you know, we're invested a lot sometimes when we do work in terms of what we see as success and failure. And I think it gets pretty easy to label what is success and what is failure.

What's a success? Term baby. Term, you know, AGA, nice, you know, term baby, good APGARS, mother breast feeds for a long time, you know, significant other was present. These are our successes. Went to - went to prenatal classes, you know, no epidural. You know, I mean, all these things that we can all pick out as our successes in treatment.

What are our failures? You know, maybe those are the ones that got the epidural that really didn't want it and we didn't do such a good job supporting them, or she didn't do such a good job of getting through. Or, you know how we do this? And we all do this.

And when we're taking care of people like substance abusers, when we're taking care of people like, people who remain in abusive situations because that's where they choose to be, I think it's really easy to begin to burnout because of how we may look at our successes and failures. And I think we have to look very realistically at what we can do and hold that. And I think

that what I would say is, if you've asked the question, you've learned to ask the question, you're now doing universal screening on all of your women, you're doing great documentation, you're a success. You're a great success. And if not one single woman in your entire service ever leaves her abuser, you are not a failure. You have not failed. And I think we have to really think about that, because we can set ourselves up very easily time and time again to go there with that.

And so taking care of ourselves as - as providers is having realistic goals as to what our work is, and realistic place as to what we can do. Form your teams, have your backup, have your people that you can talk to, don't try to do it alone, all these things that we've brought over time.

[Text on screen] End Section V: Taking Care of Ourselves as Providers.

Questions and Answers

Is the woman involved in batterer's treatment?

[Pat Paluzzi] There's also a lot of communication with the woman, which is a really important piece. They do not treat the man in isolation, and there's conversation that happens with the woman all along, at least in this particular program, I know there's a lot of conversation with the woman.

She's - not necessarily that they're like telling his stories to her, but if he's - when he's gonna be discharged from the program, she's certainly let in on that. How - you know, if there's - there's constant conversations with the counselors as well, that they don't necessarily take her conversations and bring them back in, or his so directly and bring them back out, but there is conversation with the woman, as well to keep her sort of apprised of what's going on and to keep her perspective in the treatment.

[Text on screen] Are there standards for therapists working with batterers?

[Dan Sheridan] Many states right now have statewide domestic violence councils that are made up of multidisciplinary teams. For example, in Oregon I just got in the - my mail about couple weeks ago the draft of the standards for abusive treatment that Oregon wants to be - want to set up a standards, so that anybody who is providing abuser treatment has to at least sign off on some statement that they're following these recommended standards as put forward by the State Domestic Violence Council. It's hard to standardize this through some sort of a licensure process, but at least people would be willing to sign off that they're following these standards. And then when you have court-ordered systems, the court has control over where they send them. Okay? So the court has - the court can have some control over where - and maybe the courts - the hope would be that the court would only be referring men into treatment for people who have read off or signed off on these standards.

And then if they find out that this particular council or agency is not adhering to these standards, then the court systems can stop sending referrals. And if you stop sending referrals, especially if the court's paying for this counseling, if the person has no ability to pay, then that's a loss of money. So there's - there's - there's some financial incentive if you're an organization willing to sign off on these standards, that you follow them, because if you don't follow them, you lose the

money. So there is an attempt to standardize abuser "treatment." And it's - it's broad, but it is still an attempt to keep some structure on it.

[Pat Paluzzi] CDC is also going to be doing this. CDC just has a research project that they're going to be starting where they're going to be looking at the primary batterer's treatment programs across the country and evaluating. And then they'll be like writing and publishing which they think are the most effective approaches.

[Text on screen] Is couples counseling recommended in abusive relationships?

[Dan Sheridan] I think it's important for you to hear that even to this day, and there's been great debate over there, there is still consensus among most providers that couples treatment or marital treatment, marital couples counseling is not recommended if there is ongoing abuse, that it is strongly not recommended. What may happen and what has happened is in that couples counseling she may then feel safe enough to say in that session to the therapist or the counselor something about her husband or boyfriend that is upsetting, but if there hasn't been something, you know, something well worked out, she may pay a physical and emotional price for saying that.

If there's ongoing violence, the recommendation, still, to this day is that he gets at least six months of some sort of structured abuser treatment. She during that same six months might be in support group, might be getting some individual treatment. If during that six months he has not violated any of his restraining order, or order of protection criteria, there's been no increase or - I mean, no reoccurrence of physical, or emotional, or sexual violence, then you might be able to bring them together for some joint or some couple work. But that couples therapy or couples work when there's ongoing violence is not in her best interest.

Some therapists say, well, I have him sign this contract that he won't hurt her. Well, these guys are ordered by judges to back off and they ignore that judge's piece of paper and that judge's signature. These guys are not going to be honoring that little contract that they signed with the therapist.

[Text on screen] Do women minimize violence?

[Dan Sheridan] I can't stress to you in your role, as especially advanced practice nurses, is to help her name the violence even if she's minimizing. I don't think battered women truly deny that they're in abusive relationships. I don't know if it's a true psychiatric denial. They minimize. They rationalize. They intellectualize. They'll make a million excuses. And sometimes your role could just be to stand there very firmly, very, comforting way and supportive way, but to name the violence for her.

And when she's ready to hear it, to let her know that she can come back and talk to you more about it. I think that's real important that you name it for her.

[Text on screen] What are the legal rights of undocumented women?

[Dan Sheridan] There is some legal confusion right now. There have been some laws that have been passed that if a woman is not a documented - is not here legally, some sort of, uh, documentation issues, but she has children who are U.S. citizens by birth, that if she's in an abusive situation, she can more readily get documentation status to be here legally.

There - there's also a law now that says even in the absence of having children that are U.S. citizens the fact that, if she's being abused and to be deported would be to - sending her back, especially into, maybe the town where he's from and she's from, and that's going to be putting her at risk of harm because his family's back there in Ecuador or South America or in Mexico, that we'd be putting her at risk, she can petition the Immigration Service for for documentation status to stay. There have been -

[Class Participant] [Inaudible][Dan Sheridan] This is a federal law. This is federal. Now, the law's on the books, but there has been great controversy in how it's being implemented.

[Text on screen] How can the health care community respond to the social needs?

[Dan Sheridan] How can we as health providers provide a service, that, historically the woman's community has? Women's communities all over this country have been using donated church basements, donated, usually bug-infested store fronts to have these, uh, support groups. Why not have a support group in the evening at a health care facility?

Now, we know in the evening - during the day finding a room, usually in the clinic or the hospital is kinda hard. This place is pretty booked. But in the evening things really quiet down. Why not have the support group at the hospital or at the clinic in the evening? It's safer. It's well-lit. It's protected.

And she were to say to him, the doctor or my nurse-midwife wants me to go for counseling every Tuesday night from 7:00 to 9:00. Now, he's been calling her crazy for all these years, right? So, now, of course you're, as the health provider are saying you need to go in, you know, for counseling. She - he may, if he's going to let her out of the house, he may let her go in for that. And actually, it's not counseling at all. It's a women's support group. And it's being maybe co-led by a health provider and one of the women from the local battered woman's community. Okay? But again, it's a safer environment. It's some place that we may be able to get her to go to. Now, he couldn't say to her, honey, I'm gonna go to the church basement for my women's assertiveness class. He's not going to let her do that.

[Text on screen] Is there a relationship between animal abuse and partner abuse?

[Dan Sheridan] The link between his history of being abusive to animals and that link between potential domestic violence, and especially in trying to maybe predict, or help young women predict who might be more likely to be abusive.

[Murmuring]

[Dan Sheridan] So maybe while she's on a date with the guy he drives out of his way to run over the cat that's in the middle of the road, instead of trying to avoid him, and then he laughs about it. I'm not a cat lover, but I would never go out of my way to steer into a cat. Okay?

And some guys do that and they laugh and they joke about it. But there is certainly an identified link between pet or animal abuse. We're not talking about people who hunt. We're talking about abuse of animals. Okay? Now, some people will argue that even, but we're talking about direct, and intentional, and purposeful abuse of animals, not for hunting reasons.

[Text on screen] Is there a "Batterer's Profile?"

[Dan Sheridan] There certainly seems to be a link between men who are extremely narcissistic. Now Marge would say that describes all men, but I do disagree with her on that.

[Laughter]

[Dan Sheridan] However, abusers do tend to have an over-abundance of narcissism. I mean, they're really narcissistic. That world - they have a need for that world to revolve around them. And so the - the guy that constantly makes all the decisions of where you're going to go on the date. The car's dying. He makes the decision what kinda car we're gonna be buying. I mean, these are decisions that he just sort of makes. The man that says, uh, when we get married, you're going to have my name. This is - this is not a negotiable option. You will have my name. He may say it kinda like, well, I'm kind of old-fashioned. I want you to have my name. You will have my name versus her choosing to have his name, which a lot of women have no problems. A lot of women say, hey, I have never liked my name. I like his name. I want his name. Or I'm old-fashioned. I mean, it - she - so, but if she chooses - but there's a lot of men who don't give her

that choice. You will have my name. End of discussion. That's a control issue. That's a narcissistic issue.

[Pat Paluzzi] Just to substantiate what Dan is saying, that they did some studies and they found I think something like one percent of the men had some sort of closed-head injury, because they were, again, trying to build a profile. Everybody's trying to make a profile. And they found something like one percent of the men had a closed-head injury.

And then there was something about another one to three percent - I can't remember, but it was no more than three percent were able to be diagnosed as something like sociopathic or something or another. And the rest just are not diagnosable and there is no clear profile. They're just men who don't - who exercise abuse. There's not anything else that's been able to be linked up to them in that particular study that they've done.

[Text on screen] How do you know if the woman is telling the truth?

[Dan Sheridan] It's kind of hard to basically say I think she's lying.

[Class Participant] Um-hum.

[Dan Sheridan] Or my gut feeling is I'm not sure she's telling the truth. But I would document if there's incongruencies. I've had women, very few though, in my career who I think are purposely or -- attention seeking, or lying or trying to get him in trouble, but some women will do that. I mean, women are people and, you know, they may do these things. But, you know, and there's a lot of men out there who are basically very willing to say all these women are making it up. Okay?

There probably are some women who are making it up. She may have been using some attention seeking. She - what was her secondary gains from saying that to you? How were you responding? Was she getting - she was getting something from that by telling you and you began - and then you began to - the pieces through the history wasn't fitting her affect. There were - there were pieces to that.

And at some point, having more of a therapist background with my master's degree, I would have probably felt more comfortable confronting her with my concerns, with the inconsistencies, and giving her permission to say, okay, if there's other issues, we need to talk about them. Okay?

So, yes, it can happen. I'm usually - I'm usually not a doubting Dan. I usually am the one who's going to be very quick to believe someone's history, and then they're going to have to then - I'm going to have to then be picking up on some of these inconsistencies and, you know, incongruencies. But it has happened that I have someone who that is just not making sense. And then what I'm actually scratching the surface of is this woman has some really profound psychiatric pathology.

[Murmurs]

[Dan Sheridan] It may be related to the fact that maybe she was sexually abused as a kid or maybe was witnessing or forced to watch. I mean, there's some pathology there that this is still some cry for help.

[Murmurs]

[Dan Sheridan] Is she a battered woman? Maybe not, but it's still a psychiatric cry for help. And at that point I'm going to be plugging her in for more of a traditional psychiatric eval.

[Text on screen] Can health care providers make the situation worse?

[Dan Sheridan] I think there's only a couple of things that we can do as providers that can make her situation worse. One is that we confront her abuser without her permission about his abuse and saying stop this, sir. That's going to be putting her at risk.

And the other thing that we can do I think to - to complicate it is if we then use the victim-blaming attitudes to her. You know, why do you stay? If we convey that sort of an attitude, that's not helpful and it's hurtful to her. I think by - and especially in my role has been of a clinician. I've run clinically-based programs and have talked with just thousands and thousands of women in this role.

And in part of my dissertation work, I'm almost a Ph.D. candidate. Not quite. Maybe in three weeks I will be. But, you know, part of my work has been asking women what was it that you found helpful? In your process of leaving, what were the things that you found helpful?

And they're exactly what Pat was pointing out here. Someone saying to her I believe what you're telling me. I believe you. No matter how incredible the history sounds, saying I believe you. Saying to her and you're not crazy. You are not crazy, because this dude had told her 150,000 times you're crazy, you're crazy, you're crazy, you're crazy. She begins to doubt her own sanity. Saying to her that no matter what the argument was about she didn't deserve to be beaten. That it is a crime in every state. That she can get help. She can get restraining orders. Now, that intervention, if you put all of that together, takes you as a clinician about two minutes to say. And even under managed care you can find two minutes -

[Laughter]

[Dan Sheridan] - to say to her I believe what you're telling me, you're not crazy, I'm sorry this happened to you, you didn't deserve to be beaten no matter what the argument was about, and here are some people who can really work and help you.

[Text on screen] What about when she hits him back?

[Dan Sheridan] When he hits you and you hit her, often what happens is that when she does hit him either first or hits him back, then she - he has to up the ante and hit her harder.

[Pat Paluzzi] That's right.

[Dan Sheridan] And I'll say to her it has to hurt. It has to hurt. And some women trying to be "macho" for the women, well, yeah, I hit him and I - I got him good. Yeah, he beat the crap outta me afterwards, but I got that one good one in. And again, trying to move her beyond. And I talk about then the patterns of escalating violence, and I say what happens next week when you have to escalate and he has to escalate and one of you ends up dead?

What would you like me to put on your tombstone, that I got him back or - I mean, sometimes you have to really call it for what it is. She's getting to this escalating. You have to sort of bring her back down to the fact that one of you may end up dead over this. And what are your children learning by watching this. It works. What are your children learning?

[Text on screen] Do abuse survivors seek out future abusive relationships?

[Pat Paluzzi] I've had women say to me what's wrong with me that the last three men I've been involved with have all hurt me? Okay. What is it about me that attracts? And this is where I often will pull out a quarter, and I don't happen to have one on me, and I flip it up in the air and I say to the woman heads or tails? And depending on what she called, I'll just say heads, it's an abuser, tails it's not.

Again, looking at statistics about 50/50 chance that any relationship a woman gets into she's most likely going to be abused during that relationship. And that's especially true for second, third and fourth marriages, because of course she's out there getting into relationships with men who are in the second, third and fourth marriages. And there's a reason why most of these guys are divorced.

[Laughter]

[Dan Sheridan] Not all of them, but there's a reason why many of them are. And that's because they're - they were abusive to their first and second - so often I'll say to them, it's - what is it about you? Yeah, she has some issues that she can look at as far as her self-esteem, and self-worth, but it's not as if she's attracted. It's not an attraction issue.

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