No matter where nurses work, chances are they’ll be caring for children, adult women and men, pregnant women, or older adults who are abused.

Most nurses are able to recognize obvious abuse, but unless a thorough assessment is performed, subtle signs of abuse and neglect will go unrecognized. While the number of abused children, adults, and older adults is staggering, it’s believed that those reported are only the tip of the iceberg.

Is your patient being abused?

Learn how to better recognize abuse and what steps to take if you detect it.

By Sara E. Bishop, RN,C, PhD, Patty J. Ellison, RN, FNP-BC, PhD, Deborah M. Ellisor, RN, MS, and Christine J. Harper, RN, MSN
Incidence of abuse

According to reports of the U.S. Department of Health and Human Services, 872,000 children were abused or neglected in 2004. In 79% of those cases, the abuser was a parent or parents. Neglect accounted for 60% of the 872,000 cases. It’s estimated that 3 million referrals were made to child protective services in 2004, and as many as 60,000 referrals were made per week in the United States.¹

Children less than 4 years of age fared particularly badly: 80% of children killed were in this age group, and children aged birth to 3 years had the highest incidence of abuse/neglect (16.1 per 1,000). Female children had a higher incidence of abuse/neglect than boys, but infant boys had the highest mortality rates (18 per 100,000).¹

Elder abuse is a growing, alarming public health issue that results in personal and healthcare costs for victims as well as the healthcare system.² In the United States, it’s estimated that up to 5% of community-dwelling elders are victims of abuse. Exact numbers are difficult to obtain, but studies have shown that only 1 of every 13 to 14 cases of elder abuse is reported. Of reported cases in 2004, two-thirds were women.³ Neglect accounted for 60% to 70% of all elder abuse reports made to adult protection services (APS) agencies.⁴ Experts report that at least 70% of reports of elder abuse came from third-party observers and not from direct reports by the older adult.⁵

Statistics on intimate partner violence (IPV) are far less nebulous. In 2000, 4.5 million incidents of physical abuse were reported by women and over 2 million by men. In telephone interviews of a nationally representative sample of 8,000 women and 8,000 men, 25% of women and 7.6% of men reported being raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some point in their lifetime. Lesbian women reported less IPV than did women with a male partner, while gay men experienced more IPV than men with female partners. Most incidents weren’t reported to police. Only 20% of all rapes, 25% of all physical assaults, and 50% of stalkings of women were reported; even fewer were reported by men.⁶

Research also indicates that each year over 324,000 pregnant women are victims of IPV in the United States.⁷ This has implications for both women and fetuses. Homicide data reveal that in 2000, 1,247 women and 440 men were killed by an intimate partner.⁸

Implication for nursing

Nurses and other healthcare providers have a responsibility to recognize, refer, and report abuse. In 2004, The Joint Commission established standards for identification and care of victims of physical assault, rape, sexual molestation, domestic abuse, elder neglect or abuse, and child neglect or abuse. Abuse may not be obvious to the casual observer, and because the patient may be unable or reluctant to speak of the abuse, criteria for identifying and assessing for abuse should be established and used consistently throughout healthcare organizations. In addition, staff must be aware of the requirements of the law and conduct assessments to preserve evidentiary materials and support future legal actions. Referrals and reporting guidelines must also be a part of organizational policies and procedures.⁹

In spite of The Joint Commission’s guidelines, surveys of physicians, nurses, nurse practitioners, patients, and chart reviews indicate that consistent screening isn’t practiced, particularly in the area of IPV and older adults. Identified as barriers to screening were individual attitudes and biases, lack of education, lack of time, lack of personal comfort with topic, personal history of abuse, and fear of offending patients. Other barriers included a lack of confidence in handling disclosures, language or cultural issues, and belief that violence isn’t an issue for patients.⁵,¹⁰,¹¹

It’s important to develop an understanding of abuse and to know how to handle patient disclosures.

Types of abuse

Definitions and types of abuse vary by source. One source, the Uniform Definitions proposed by the
Types of abuse

Child abuse\textsuperscript{13,14}
An act or failure to act by a parent or caretaker, which results in serious physical or emotional harm, sexual abuse, exploitation, or death of a child, and/or any act that places the child in risk of serious harm. (The definition of a minor child varies by state.)

Elder abuse\textsuperscript{15,16}
Intentional acts of commission or omission, usually repetitive, which result in harm or threatened harm to the elder’s health or well-being by a caregiver or other person in a trusted relationship with the elderly person (including failure to provide basic needs or to protect from harm). (There is no uniform age to define “elder.”)

Intimate partner violence\textsuperscript{17}
A pattern of behaviors that may include physical injury, psychological abuse, sexual abuse, progressive isolation, stalking, and threats aimed at establishing control by one partner over the other.

For the Centers for Disease Control and Prevention’s definition of intimate partner, visit: http://www.cdc.gov/ncipc/pubres/ipv_surveillance/05_uniform_definitions.htm.

Neglect\textsuperscript{4,13,15,16}
Examples include harmful, malicious, or ignorant deprivation of adequate food, clothing, shelter, medical care, financial, emotional or educational necessities; abandonment by someone who has assumed care or custody of a vulnerable person; and self-neglect by the elderly person.

The abuse may be intentional or unintentional (stemming from ignorance or genuine inability to provide care).

Emotional or psychological\textsuperscript{7,12,18}
Examples include enforced isolation; controlling what one can and can’t do; prohibiting access to transportation or telephone; withholding information; deliberately doing something to make the person feel diminished or embarrassed; forcing the victim to engage in illegal activities; using children to control victim’s behavior; threatening loss of child custody; destroying property; intimidation; threats of violence (physical or sexual) or murder to self, children, or pets; and threats of weapon use.

Sexual\textsuperscript{16-18}
Examples include forced oral, anal, or vaginal intercourse; including use of objects for penetration and/or intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks with partner or others against the person’s will, or if the person is unable to communicate unwillingness (due to illness, disability, under influence of alcohol or drugs, or due to intimidation or pressure); forced voyeurism or use of pornography; and human trafficking for sex.

When children are involved, examples include the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Economic\textsuperscript{7,16}
Examples include deprivation of key resources, including food, clothing, medication, healthcare, transportation, or money; improper use of an adult’s funds, resources, or property; fraud; embezzlement; forgery; falsifying records; and coercing transfer of property or funds.

Verbal\textsuperscript{7}
Examples include name calling, cursing at, screaming at, or humiliating another privately and in front of others.

Physical\textsuperscript{7,16,18}
Examples include throwing objects at someone; pushing; slapping; hitting; poking; punching; kicking; choking; hair pulling; biting; burning; shaking; using a weapon or use of restraints or one’s body, size, or strength against another person; scratching; or coercing other people to commit any of the above acts.

Stalking\textsuperscript{19}
Examples include repeated harassment by phone contact/hang-ups, e-mails, letters, surveillance at home, work, and/or in day-to-day living.

Note: Examples are those most commonly used, but aren’t meant to be all inclusive.
Centers for Disease Control and Prevention, divides abuse types into four broad categories, while other sources related to intimate partner violence separate verbal, psychological (emotional), and economic abuse into individual categories.\textsuperscript{7,12}

Rarely, if ever, is neglect a category in IPV, but an understanding of what constitutes neglect is important when considering child or elder abuse. For purposes of this article, definitions and types of abuse are divided into categories by broad groups (child, elder, intimate partner) and then by more discrete clinical groups. (See “Types of abuse.”)

**Risk factors**

Research has shown a higher risk for abuse exists among certain age levels, socioeconomic levels, and gender, but nurses must remember that neglect and physical, psychological, and sexual abuse are found at every age level, at all socioeconomic levels, and with each gender. Common to all levels of abuse are community and societal factors that include tolerance for violence, a high level of violence, poverty, overcrowding, poor support for families, traditional gender norms, and cultural mores.\textsuperscript{20} (See “Risk factors for abuse.”)

**Interviewing skills**

During the assessment interview, the nurse should assess the level of cooperation, emotional, and mental status of the victim, interaction patterns between the caregiver/partner and victim, as well as observe for signs of fear, anxiety, or hostility, and other nonverbal cues.

The interviewer should remain neutral in facial expression, voice tone, and posture, and should refrain from leading questions.\textsuperscript{14,23} When possible, the interview should be conducted in private with only the nurse and patient present. If needed, a language line service or translator who isn’t a friend or family member should be used. The patient should be informed of the confidentiality of the translator and of the limits of confidentiality on the part of the interviewer.\textsuperscript{24,25}

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## Symptoms of Abuse

### Physical Abuse

**Children**
- Multiple bruises of various colors, scabs on old injuries
- Central distribution of injuries—abdomen/back, genital area, face
- Patterned injuries—bites, belts, cords, slaps
- Burns—cigarette, immersion
- Fracture frequently spiral
- Hemorrhage—subdural
- Facial injuries—orbital hematoma
- Resistance to going home

**Elder**
- Multiple bruising in protected areas—different stages of healing
- Pattern injuries
- Attempts to hide part of body on examination
- Burns in unusual places
- Fractures—unexplained
- Hemorrhage—subdural
- Pressure ulcers/untreated wounds
- Medications not taken as prescribed/unfilled prescriptions
- Financial issues: Unexplained withdrawals from savings accounts, unexplained shortages of money, sudden transfer of assets to relative, unpaid bills, disappearance of bank statements, jewelry/money, personal possessions, reluctance of caregiver/family to pay for necessities

**Intimate Partner Violence**
- Facial/neck injuries—back of head
- Central distribution of injuries—breast/abdomen
- Pattern injuries—bites, belts, cords, circular contusions 1 to 1.5 cm consistent with finger pressure
- Burns—cigarette, rope
- Fractures—suggest defensive posture, especially wrists, forearms, feet
- Hemorrhages—subconjunctival
- Fingernail markings: commas or semicircles made by fingernails cutting into skin
- Scratch marks: superficial, long, narrow; claw marks
- Grouped parallel markings
- Strangulation/choking—hanging/ligature/manual; finger marks/scratches on neck
- Violence often increases during pregnancy: injuries often to breast or abdomen, trauma to genitalia, unexplained spontaneous abortion, miscarriage, premature labor

### Emotional Abuse

**Children**
- Developmental delays
- Poor school performance, difficulty focusing
- Fear, distrust of others
- Lying, stealing, other delinquent behavior
- Anger, hostility, aggression

**Elder**
- Depression, fear, withdrawal, apathy, anxiety
- Makes great efforts to please
- Appears afraid of relative or caregiver
- Shows fear/apprehension, distress before/after visit of relative/caregiver/visitor
- Reluctance to be discharged to previous circumstances
- Demonstrates sudden mood/behavior change
- Aggression

**Intimate Partner Violence**
- Depression/fearful of visitors and caregivers
- Eye contact may be poor
- Withdrawal
- Partner may exhibit controlling behavior, coercion, or possessiveness

### Sexual Abuse

**Children**
- Frequent urinary tract infections (UTIs)
- Anogenital itching, lacerations, vaginal discharge, bleeding
- Sexually transmitted diseases (STDs)
- Pregnancy, promiscuity, precocious sexual behavior or seductiveness
- Delinquency or truancy, aggressive behavior or overcompliance
- Frequent somatic complaints
- Mood swings, sleep disturbances
- Anorexia, bulimia

**Elder**
- Recurrent UTIs
- Pain/itching/injury anogenital/abdominal area
- Bruising/bleeding external genitalia
- Torn/stained/bloody underclothes
- STDs
- Unexplained problems with urinary catheters
- Difficulty walking—discomfort in genital area
- Uncharacteristic change in attitude towards sex

**Intimate Partner Violence**
- Labial/vaginal hematomas; vaginal lacerations
- Dried blood/semen in vaginal area
- Rectovaginal foreign bodies
- Unexplained pain in genitalia
- STDs, particularly if recurrent
It’s important to gently assess the caregiver or family member for caregiver burnout, a precursor to abuse and neglect.\textsuperscript{2,27}

**Intimate partner:** General techniques for interviewing should be observed with IPV patients. It’s preferable that no children over 2 years of age be present for the interview. If both partners are injured they should be assessed individually. The HEADSS interview for adolescents is a psychosocial risk assessment instrument that’s an acronym for Home, Education, Activities, Drug use and abuse, Sexual behavior, and Suicidality and depression. The tool is helpful because it addresses home, education, activities, dating, sex, and substances with open ended questions.\textsuperscript{24,25}

**Symptom assessment**
Commonalities of symptoms exist among child, elder, and intimate partner victims of abuse, but differences exist within those commonalities. Symptoms are described by type of abuse as well as age groupings. (See “Symptoms of abuse.”)

**Screening tools**
Review of the literature revealed numerous screening tools for abuse or neglect. The tools referred to in this article represent ones that are easy to use, applicable to the clinical setting, and can be conducted in a short amount of time in the acute care setting.

**Child:** Reliable screening tools for child abuse are few. Questionnaires are most effective in identifying risk factors, but falsely labeling families as potential abusers is a primary limitation to most screening instruments. Also, children may be too young to answer or answer reliably, parents and children may be ashamed or fearful to admit abuse, and parents may not regard use of physical punishment as abuse. Consistency in healthcare providers’ screening questions such as “What do you do when he misbehaves?” or “Have you ever been worried that someone is going to hurt your child?” may provide openings for discussion and referrals of child abuse. The answers to these questions and follow-up physical assessment of the child provides information to guide referral.\textsuperscript{31}

**Elder:** The Brief Abuse Screen for the Elderly is a five-item screen, concerned with caregivers and/or care receivers, administered by a healthcare provider or social worker. The questions use a Likert-type scale with no scoring, and the provider must be familiar with the patient situation.\textsuperscript{32}

The 6-item screen Hwalek-Sengstock Elder Abuse Screening Test is a revision of the 15-item Elder Abuse Screening Test. The questions elicit information concerning physical, sexual, verbal, and economic abuse.\textsuperscript{33,34}

**Intimate partner violence:** RADAR is a pneumonic device ( Routinely inquire about current and past violence, Ask direct questions, Document findings, Assess safety, Review options and referrals) that reminds providers and nurses of steps in screen-
HITS (Hurt, Insult, Threaten, Scream), a four-item survey developed for screening women in clinical settings, has also been validated for use with men. The Abuse Assessment Screen, a survey of four short questions developed to detect abuse in pregnancy, has been shown to increase detection of abuse. This screen contains a body map for documentation.

Cultural and gender considerations
Not all tools have been studied specific to culture. With the increase in cultural diversity in the United States, nurses must be educated to conditions that might appear to indicate abuse. Nurses must learn generalities about family and relationship dynamics in different cultures while remaining aware that individual patient perspectives may exist. Gathering cultural information from each patient brings out those perspectives.

While some cultural practices are specific to age groups, others encompass all age levels. In Asia, “coining,” or cao gio, involves rubbing a hot coin over the back in a linear pattern resulting in lines where blood has come to the surface and appears as bruising. This practice does not cause pain and is believed to provide access for “bad winds” to escape the body relieving the body of illness.

In China, “cupping,” in which a heated cup is pressed to the skin, results in a circular bruise/burn to promote healing. The rationale for cupping use is similar to coining and the practice sometimes results in first or second degree burns. Moxibustion, often combined with acupuncture, consists of burning incense or heated yarn to warm acupuncture needles for relief of stress or pain and to encourage an elevated inflammatory response. Burns and scarring can sometimes result when the moxi stick is placed on the skin.

Child: Mongolian spots are bluish-black birthmarks that usually occur over the sacrum/buttocks and may be mistaken for bruises. Mollera caída, or sunken fontanel, is treated by various folk remedies, such as pushing up on the soft palate, sucking on the fontanel, and sometimes shaking an infant who is dehydrated. Biting a child is common to many cultures so that teeth marks appear on the child’s skin. Chinese parents may pinch and yank the hair of children. Pinching the skin to allow bad forces to come out sometimes results in temporary dermabrasions. In parts of Africa, Asia, and the Middle East, excision of the clitoris and/or labia minora and suturing of the vaginal opening (infibulation) is practiced.

Elder: In older adults, spiritual and cultural beliefs of the patient, family, and caregiver must be considered. Many American elders who grew up during the Great Depression learned self-reliance and stoicism that may jeopardize the elder’s health by their reluctance to speak up.

Intimate partner violence: Women who don’t speak English are at risk for increased isolation. The use of culturally appropriate materials that consider literacy level, language, and cultural perspective should be
used for teaching. Culturally specific services such as women’s shelters increase the woman’s safety and decrease the risk of returning to the abusing partner.  

Gender issues
As with culture, some gender issues may prevent disclosure. Gender issues can be managed by questions using neutral terminology such as “has anyone” or “has your partner” rather than “has your husband/wife ________.” Don’t assume the patient is heterosexual or the partner is a spouse.

Barriers to disclosure for men include issues that women face, such as fear, lack of resources, and fear of not being believed or being ridiculed. Cultural beliefs that men should be strong and invulnerable include both heterosexual and gay/bisexual/transgendered men and impact support systems like the police, judicial, and medical systems. Even as victims, men have a higher risk of losing child custody. Other barriers for abused men include the stress of acknowledging physical or emotional dominance of a female partner, higher social stigma, and feeling emasculated.

Documentation
Documentation of suspected abuse is a part of the medical record and should be accurate, objective, and comprehensive. As with any nursing documentation, general principles require that the medical record be in permanent ink, factual, accurate, complete, current, legible and organized, and signed with the recorder’s full name and status. Documentation guidelines should be adhered to in all instances because the record may be subpoenaed by the court system for use in determining child custody, interventions by child protective services (CPS) or APS, orders of protection, or criminal convictions. A complete nursing history of the injury/condition as well as a head-to-toe physical assessment addressing hygiene and mental status should be included. Certain specific guidelines will help the nurse who is documenting data in cases of suspected abuse. (See “Documentation tips.”)

Reporting
Reporting mandates vary greatly by state and types of abuse. Following national and state laws, as well as nursing practice guidelines, helps ensure that instances of abuse are reported in a timely and factual manner. The nurse should be aware of the state’s Nursing Practice Act guidelines as well as state laws governing reporting of abuse for patient’s of all ages.

Child: In 1974, the United States Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), which set the stage for state legislation addressing mandatory reporting of child abuse. Since the original CAPTA legislation, all 50 states and the District of Columbia (DC) have passed mandatory reporting acts for child abuse, and nurses are included in the healthcare providers required to report abuse and neglect. Child protective services oversee the process of investigating these reports of suspected child abuse. Most states have phone hotlines and healthcare providers submit phone reports followed by written reports. If there’s reasonable cause to believe that abuse has occurred, the case should be reported to CPS. To determine if a report should be filed, ask the question, “would a reasonable, prudent nurse consider these signs and symptoms to be caused by abuse or neglect?” If the answer is “yes,” report. Mandatory reporting laws grant civil immunity to those who make good faith reports about suspected cases of child abuse: anonymity and confidentiality of the reporter varies according to the state.

Elder: In most states, elder abuse reporting is required by law. Currently all 50 states and DC have laws that authorize the provision of APS in elder abuse cases. As of 2002, 44 states plus DC had mandatory reporting provisions in their APS laws. The six states that don’t have
mandatory reporting laws are Colorado, New Jersey, New York, North Dakota, South Dakota, and Wisconsin.

Statutes, definitions, and reporting requirements for elder abuse vary considerably from state to state, even among those that mandate reporting. Some healthcare providers may be unfamiliar with elder abuse legislation and falsely believe only substantiated cases can be reported. Some may also have the misconception that the law requires them to obtain the patient’s approval before reporting.53

**Intimate partner victim:** At present, six states (California, Colorado, Kentucky, New Hampshire, Rhode Island, and New Mexico) have mandatory reporting requirements for injuries that are the result of domestic violence or abuse. Many states mandate reporting of injuries that are specific, regardless of perpetrator, such as gunshot or stabbing.54,55 If a state doesn’t have mandatory reporting, a viable option for the nurse is to discuss pros and cons of reporting with the victim and consider whether reporting will make him or her safer or place him or her in more danger.56 One important footnote to the reporting of domestic violence is that if a child or elder witness is endangered by the abuse, the situation falls under mandatory reporting guidelines for child/elder abuse.57

Controversy exists in both the elder and IPV arenas over whether mandatory reporting is positive. Mandated reporting may deter seeking medical attention, disclosing abuse, and precipitate or exacerbate further violence. The possibility of litigation against the reporter, interference with victim autonomy and privacy, the affect on the nurse-patient therapeutic relationship, and punishment of unintentional abusers (elder abuse) all complicate the issue. It’s feared that in some cases, reporting or arresting the abuser places the victim at increased risk for violence and death.53,54

**Referrals**

While reporting abuse is mandated by law, The Joint Commission requires each institution to have in place referral policies and procedures when abuse is suspected or identified.9 Resources are available on the local, state, and national levels. Advocate groups offer specific services to children, the elderly, and abused adult men and women.

**Child:** When abuse is suspected, prompt secondary intervention through referrals to child protective services is mandated to prevent further injury, harm, or death. Research demonstrates that early secondary intervention is effective in decreasing the morbidity, mortality, and escalating cycle of violence.58 By identifying high-risk families and patients, nurses can make referrals in the hope of interrupting the cycle of violence and increasing coping skills and healthy communication in families. Referral options include mental health services, anger management counseling, women’s shelters, family support groups, family counseling, mentoring programs for parents, and crisis intervention centers. Encouraging attendance at parenting classes for high-risk mothers, as well as requesting home visitation by nurses, is especially effective in prenatal and postpartum populations. In one study, home visits by nurses to at-risk prenatal and postpartum families decreased the incidence of abuse and neglect for as long as 15 years after the intervention.59 The Child Abuse Hotline number is 1-800-4A CHILD (1-800-422-4453).

**Elder:** Indications for referral of older adults to social services are: evidence without sufficient clinical explanation; subjective complaints made by the elder of mistreatment; or evidence of abuse, neglect, exploitation, or abandonment.4 When a referral is indicated, call the protective services agency in the state where the elder lives. Each state has an elder abuse hotline that should be available to nurses and patients.60

**Intimate partner victim:** For victims of IPV who deny the abuse or aren’t ready to report or leave their partner, the nurse should validate feelings, support the victims’ right to be safe, and offer information in the form of written materials and phone numbers for local and national hotlines and resources. Don’t send information by phone, mail, or e-mail, as the abuser may intercept the message. Often, information is better...
received if delivered indirectly in the context of “perhaps someone you know may need this information.”

The nurse should encourage formulation of an escape plan including a safe place to meet, a prepacked bag with clothing (include clothing for children), cash, credit cards, and important documents such as driver’s license, phone numbers, and bank account information. Awareness of assessment strategies, communication for an abused child, elder, or adult. As such, nurses have great privilege and great responsibility. Lines of communication may be opened and the abused patient can understand that someone cares, will listen, and will help, even though the person doesn’t disclose abuse at that first contact. It may take several askings before the patient is ready to describe the abuse and consider options.

Nurses must ask about abuse through a screening protocol and respond when abuse is disclosed. If not, the patient may continue to live in a situation that, at the least, is painful, and at the worst, deadly. Awareness of assessment strategies, communication skills, and reporting/referral options will allow nurses to intervene with these vulnerable patients and make a difference in the patient’s life.

First line of defense

Nurses are often the first healthcare system contact for an abused child, elder, or adult. As such, nurses have great privilege and great responsibility. Lines of communication may be opened and the abused patient can understand that someone cares, will listen, and will help, even though the person doesn’t disclose abuse at that first contact. It may take several askings before the patient is ready to describe the abuse and consider options.

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References


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