Addressing the Health Consequences of Domestic Violence

The Pandora Effect

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I begin today with a compelling old myth: The story of Pandora's box. You probably remember something of it: Beautiful Pandora, created by the Olympian gods for Zeus, received a box as a gift and was forbidden to open it. But beautiful Pandora was curious and she opened the box anyway. In one horrifying moment, all the earth's furies—trouble, old age, insanity, plague, sorrow, vice, crime—flew out of the box, never again to be contained by humankind.

Furies and trouble. That is why, when we hear the phrase "opening Pandora's box," we think we are being warned, as in the old adage, "Let sleeping dogs lie." Don't wake trouble up, we say. But many people don't realize that there is more to the Pandora story, and that is the story's ending.

All the furies flew out of the box, but something remained. And what do you suppose remained in the box that had held the furies? It was hope. Hope: implying that after trouble, hope never entirely leaves us.

I come to you this morning with a challenge. And that is to *rethink* the phrase, "opening Pandora's box." As you'll see, many healthcare providers in the past have declined to recognize signs and symptoms of domestic violence precisely because they were afraid to open what they saw as Pandora's box. They didn't want to deal with the complexities and uncertainties of domestic violence. But we can rethink that Pandora phrase, remembering the hope that remained in the box, as we address the issues of domestic violence.

Today's terminology refers to domestic violence as intimate partner violence (IPV). Traditionally, healthcare has approached this issue by using a standard healthcare intervention for cases of intimate partner violence. Today I challenge you to move beyond this limited intervention. It is time to now incorporate violence prevention into our medical practice by diagnosing and treating the healthcare ***consequences*** of intimate partner violence. It is time to open

Pandora's box and find the hope, still there, at the very bottom.

A. Definition

By definition, intimate partner violence is a form of family violence. It has been interchangeably referred to as domestic violence, spouse abuse, partner abuse, wife abuse or wife battering. It is characterized by an unhealthy pattern of coercive behaviors with the intent of one partner to dominate, control and victimize the other partner. The goal of controlling another through the abuse of power and control is the common feature in IPV.

B. Impact on the Healthcare System

Intimate partner violence is definitely a healthcare issue. Recent studies have shown that most healthcare visits are made because of common symptoms for which no identified pathology is found.[1] We now have evidence that suggests that victims of violence seek healthcare more often than nonvictims and that the *severity* of victimization is a powerful predictor of health care costs.[2] IPV is not cheap. The cost to our society is enormous. Physical injury from interpersonal violence causes approximately $10 billion of direct healthcare cost each year. Another $23 billion results from lost production per year.[3]

C. Current expectations of the Healthcare System

The overall goal intervention in IPV is to assure patient safety and well-being. It is a lengthy process requiring experts in domestic violence who have access to a wide range of legal and community-based services. This overall process is beyond the scope of healthcare providers at any given moment. It is, however, aided by a very specific healthcare intervention consisting of five easy and significant steps: (1) Identification, (2) documentation, (3) provision of safety, (4) referral and (5) assurance. The actual intervention, conducted by IPV prevention experts, is undertaken after the specific healthcare intervention is performed.

This is no different from what we expect of physicians in any healthcare setting. Consider the case of the patient presenting to an urgent care setting with a chief complaint of right lower quadrant (RLQ) pain. Information is obtained and analyzed to discern whether or not this pain might represent a diagnosis of appendicitis (Identification). Findings of the history and physical examination are recorded along with progress notes of what happens during the evaluation of the patient (Documentation). If it appears that surgery may be needed, fluids and food are restricted (Provision of safety). A surgeon is called to see the patient (Referral). The patient is reassured that the best care will be provided (Assurance). These five steps comprise the initial healthcare intervention of addressing the patient's problem. The actual, more specific intervention, exploratory surgery, occurs at a later time in the OR.

This specific healthcare intervention has gained acceptance by many experts. This is appropriate because in the healthcare field, we tend to believe that most of the IPV victims are the patients presenting with fresh or healing injuries.

While many IPV patients do present with injuries, it is not the most common presentation. Far more common are the women presenting with medical problems that do not reflect current or very recent injuries.

D. Consider this scenario

A young woman, Anita, presents with abdominal pain that seems to defy diagnosis and medical help. She has seen many doctors to no avail. Her current doctor doesn't seem to have the opportunity to spend much time with her during her visits, but he never gives up trying to find out what is causing her pain. She has undergone test after test and each time the newest one comes back negative, her physician orders a new test, prescribes a new medication and assures Anita that they will keep pursuing the problem until he can find an answer.

Time goes by. Anita's husband takes a new job and the family moves across the country. Shortly after the move, the abdominal pain returns. Anita makes an appointment to see a new doctor in her husband's healthcare plan.

When Anita arrives for her appointment, she finds posters lining the hallway of the clinic. Some advertise flu shots and give tips on how to manage blood pressure. Others stress the value of exercise and good diet. In the bathroom, Anita sees a large poster asking if the she is a victim of domestic violence. Beside the poster is a rack of pamphlets telling her where to get help for domestic violence.

In the new doctor's waiting room, Anita is given a healthcare inventory form to complete. Buried in the questionnaire is a question asking about the presence of domestic violence, now or in the past.

She answers "no." Paul, her gentle husband would never touch a fly. He treats her like a princess.

When Anita meets her new doctor, she is asked a number of questions about her pain. Suddenly her new doctor asks her if anyone she knew was hurting her in anyway? Did she feel safe at home? When Anita answers, "no," she is asked if that might have occurred in the past. The question triggers her memory of her first abusive marriage, which Anita has long since gotten "over it." Anita asks her doctor why this question is being asked.

Her new doctor says, "Well, in my experience, I find that sometimes abdominal pain that comes and goes and doesn't lend itself to a definite diagnosis is not uncommonly linked

to a history of abuse. That's why I want to know if anyone is hurting you now or has hurt you in the past."

Anita begins to sob and pours out the story of her first marriage. Suddenly she stops. Anger flares up, "Does this mean you think that this is all in my head?" she challenges her new doctor.

The doctor smiles and says no. Then she points to Anita's chart and reads the chief complaint aloud, "Abdominal pain." She looks at Anita and smiles. Then she says, "I think if this were all in your head, your chart would read, 'headache.'"

The new doctor goes on to explain that past abuse sometimes produces deep pain that literally seems to "bury itself" inside the body. Long after the memory of the abuse has faded, the body remembers and carries around pain down deep. She also explains that there are a number of other things that cause abdominal pain and that they will be doing a thorough diagnostic evaluation. Meanwhile she provides Anita with information about domestic violence and its impact on the body. She also arranges for Anita to see the social worker who runs a weekly support group for women who have suffered domestic violence and are now in the process of putting their lives back together.

Does Anita's case represent the healthcare response to domestic violence in the United States at this time? Rarely. But the good news is that it could well have happened in Dallas, TX at the Parkland Hospital's Violence Intervention Prevention (VIP) Center. This Center was the first full-service, hospital-based, treatment-oriented and physician directed center in the United States dedicated to victims of violence.

Now, many other agencies and healthcare systems are beginning to understand the link between domestic violence and healthcare problems. Towards this end, widespread education and training is underway to teach physicians and healthcare providers how to identify and address domestic violence. These educational endeavors seek to explain to them what they can each one of them can do to "break the cycle of violence" by helping to prevent future episodes of domestic violence in their patient population.

From these centers and activities we are beginning to learn that the impact of repeated abuse does, indeed, leave a lasting "impression" on the health of the victim of abuse. This impact, what I call the Pandora effect, lingers long after the bruises fade, the bones mend and the abuse is over. Still, many of the victims, their friends and relatives and those who serve them in the domestic violence advocacy, medical and law enforcement communities fail to understand how significantly this lingering footprint of violence is effecting their well-being and their ability to function and carry on a normal life.

There is now mounting evidence in the medical literature that IPV has long-term negative health consequences for survivors, even after the abuse has ended. To investigate this issue, Dr. Jacquelyn Campbell and colleagues published a study on *Intimate Partner Violence and Its Physical Health Consequences* in May of 2002. These researchers surveyed 2005 women who were between the ages of 21 and 55 years of age and enrolled in a metropolitan health maintenance organization servicing multiple sites. Using an accepted screening tool known as The Abuse Assessment Screen, the researchers identified 201 women who had been physically and/or sexually abused between January 1, 1989, and December 31, 1997. From the remaining women, they randomly selected a sample of 240 never-abused women who served as case controls. They then compared the general health perceptions of the abused women to the never-abused women.

They found that the abused women had significantly more headaches, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, pelvic pain, painful intercourse, urinary tract infections, appetite loss, abdominal pain, and digestive problems than the never abused women. The abused women also had more gynecological, chronic stress–related, central nervous system, and total health problems.[4] In addition, recent case reports in the literature describe stokes and Transient Ischemic Attacks following carotid trauma, sustained from manual strangulation,[5] a not uncommon form of abuse which occurs in domestic violence attacks.

Many authors report that there are even numerous health problems associated with past abuse. Walker, et al in their article, *Adult Health Status of Women with Histories of Childhood Abuse and Neglect*, found that the 25 most commonly used diagnostic codes used for these patients included infectious diseases (vaginitis, urinary tract infection, upper respiratory infection, sinusitis, rhinitis, pharyngitis, bronchitis, cellulitis), pain disorders (neck pain, migraine, dysmenorrhea, headache, back pain, abdominal pain), mental health diagnoses (stress, depression, adjustment problems, marital discord), and other diseases (hypertension, diabetes, dermatitis, asthma, allergy, acne, abnormal menstrual bleeding). These authors also found repetitive adult behaviors that have the potential for creating or worsening health problems. These included smoking, use of alcohol, driving while intoxicated, avoiding regular gynecological examinations, not wearing seat belts, sedentary lifestyle, and high-risk sexual encounters. [6]

II. Pandora Effect

It is time for the healthcare system to step forward and lead the way in addressing the healthcare consequences of intimate partner violence.

Domestic violence advocates, family, friends and knowledgeable law enforcement officials, healthcare providers and the patients themselves, from their own experience, have known for sometime that there was something "not quite right" about the victim of abuse who is trying to reclaim her life. To date, however, there has been no name for this.

IPV victims, current or recovering, carry their own unique burden: Life after repetitive abuse is never the same. The abuse leaves a strong imprint on the body and soul long after the bruises have faded and the bones have mended. There are lingering health and social consequences that impact the IPV victim's post-abuse functioning and well-being. Let us begin by giving the problem a name. I call this constellation of lingering consequences the Pandora Effect. When we give a name to this condition, we validate the issue and our patients. Let us validate our patients by addressing this Pandora Effect through focused healthcare, education and research. The name, the Pandora Effect, does one more thing. This name defines IPV as a women's health issue.

I leave you today with this challenge: the next time you see a women who presents with a headache or chronic pain or a sexually transmitted diseases or digestive problems, open your eyes and look hard. You may find that you are "seeing Anita." When you see "Anita," have the courage to open Pandora's Box and help her with confidence, skill and the healer's art. Do so and you will find … ***Hope.***

Thank you.

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Facts That Victims of Choking (Strangulation) Need to Know!

Strangulation has only recently been identified as one of the most lethal forms of domestic violence: **unconsciousness may occur within seconds and death within minutes.** When domestic violence perpetrators use strangulation to silence their victims, not only is this felonious assault, but it may be an attempted homicide. Strangulation is also a form of power and control which may have devastating psychological effects or a potentially fatal outcome.

Victims of strangulation will first feel severe pain. If strangulation persists, unconsciousness will follow. Victims may lose consciousness by any one or all of the following methods: blocking of the carotid arteries in the neck (depriving the brain of oxygen), blocking of the jugular veins (preventing deoxygenated blood from exiting the brain), and closing off the airway, making breathing impossible.

Very little pressure on both the carotid arteries and/or veins for ten seconds is necessary to cause unconsciousness. However, if the pressure is immediately released, consciousness will be regained within ten seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death will occur in 4 to 5 minutes, if strangulation persists.

Be aware that strangulation may cause the following symptoms and/or consequences: difficulty breathing, raspy, hoarse or loss of voice, coughing, difficulty swallowing, nausea, vomiting, changes in behavior, hallucinations, headaches, light headedness, dizziness, urination or defecation, miscarriage, swollen tongue or lips. These symptoms may be an early indication of an internal injury such as swelling, bleeding, fractured larynx ("voice box") or hyoid bone, seizures, pulmonary edema (lungs filled with fluid) or death within 36 hours due to progressive internal injuries and/or complications.

Victims should look for injuries on their face, eyes, ears, nose, mouth, chin, neck, head, scalp, chest and shoulders, including: redness, scratches or abrasions, fingernail impressions in the skin, deep fingernail claw marks, ligature marks ("rope burns"), thumbprint-shaped bruises, blood-red eyes, pinpoint red spots called "petechiae" or blue fingernails.

Victims should also seek medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, light headedness, involuntary urination and/or defecation.

Although most victims may suffer no visible injuries whatsoever and many fully recover from being strangled, all victims, especially pregnant victims, should be encouraged to seek immediate medical attention. A medical evaluation may be crucial in detecting internal injuries and saving a life.