

# Addressing the Health Consequences of Domestic Violence

By

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Let me tell you the story of Anita. Anita is a woman who struggled for years with abdominal pain. The pain was severe and the pain came often. Yet it defied diagnosis and conventional medical treatment. She saw many doctors to no avail. She underwent many tests and tried many medications. *Nothing* helped.

Desperate, Anita switched health plans and made an appointment to see yet one more doctor. *This time*, things were different.

When Anita arrived for her appointment, she found posters lining the hallway of the clinic. Some advertised flu shots. Some gave tips on how to manage blood pressure. Others stressed the value of exercise and good diet.

Then something *really* different happened.

When Anita went to the Ladies Room, she found a large poster asking if she were a victim of domestic violence. Beside the poster she saw a rack of pamphlets telling her where she could get help for domestic violence.

In the new doctor's waiting room, she was asked to fill out a healthcare inventory questionnaire. Buried deep in

the questionnaire was a question asking about domestic violence.

She checked "no" to that question. Her gentle Jonathan would never touch a fly. He treated her like a princess from the day they met.

Then Anita met her new doctor who began by asking a number of questions about her belly pain. Suddenly Anita was asked if anyone she knew was hurting her in anyway? "No," she answered. "Did she feel safe at home?" the doctor continued. She answered, "Yes, very safe."

Then her new doctor asked her if she had *ever* been abused in any way or form. This question triggered Anita's memory of her first abusive marriage, a marriage that ended when her drunken husband drove his car into an oak tree that was far mightier than he.

"Why are you asking me these questions?" she asked her new doctor.

The doctor replied, "Well, in my experience, I find that sometimes abdominal pain that comes and goes *and* doesn't lend itself to a definite diagnosis can be linked to a history of abuse. That's why I want to know if anyone is hurting you now. And if not now, have you been hurt in the past?"

And she had been.

Anita began to sob. She poured out the painful story of her first marriage, a marriage that started in love and ended with shouts and slaps from her quick-to-anger husband.

At the end of her story, her tears gave way to anger. "Does this mean that *you* think that this is all in my mind?" Anita demanded.

"No," said the doctor. Then the doctor pointed to Anita's chart and read the presenting medical problem aloud, "Abdominal pain it says here." Then the doctor, with a gentle smile said, "I think if this were all in your mind, your chart would not read "abdominal pain." Instead it would read, "headache."

The doctor then laid out a treatment plan. They were not going to assume anything. They would start with a thorough diagnostic evaluation. Meanwhile, Anita was given information about domestic violence and its impact on the victim's health. Anita was referred to a social worker who ran a weekly support group for women who had suffered domestic violence and were now in the process of putting their lives back together.

All the new tests came back negative and a diagnosis of "spastic colon" was made. The doctor prescribed medication to help quell the symptoms. Meanwhile, Anita began to understand how her past abuse was related to her pain, pain that

she never had until that first marriage ended.

Anita soon started seeing a counselor in the chronic pain clinic and began to use expressive writing as a self-exploratory tool. Her progress was slow and steady. Eventually Anita emerged essentially pain free and no longer needed medication. Other changes also occurred. She began to sleep better, her concentration was better and she found she had more energy.

Today, Anita is in robust health and volunteers at a local domestic violence shelter where she is quick to share her story.

The ending to Anita's story is a happy one. Unfortunately Anita's story is also a very rare story. Even today, many physicians remain unaware of the connection between past trauma and abuse to today's health status. They fail to ask about abuse and the patient continues to suffer.

And that, Ladies and Gentlemen, is why we are here today.

We are here today to honor, to celebrate and most important of all, to support the good work of STAND which operates under the direction of Executive director Gloria Sandavol. I want to thank all the individual who supported my participation in this event, especially Christina Dean, Patti Cawood, and my colleague Dr. Dawn Marie Wadle.

In addition, it's an honor to be here with you today as *you* honor two major forces in healthcare working to address domestic violence. Both of these dedicated individuals have inspired my own work over the past decade: Dr. Brigid McCaw and Marianne Balin. Congratulations to you both.

When you visit the STAND webpage, you will discover that the mission which inspires their work is their dream of



Such an important goal requires much effort.

In the meanwhile, domestic violence is still with us and we have much to do. For you see, victims of domestic violence need strong helping hands. And the strong helping hands need to understand that domestic violence is not over when the victim is safe. It's not over until justice has been served. **And even then, it's not over.** It's not over until the victim is safe, until justice

has been served, and *the victim is well.*

Life after abuse is never the same. When trauma happens, the victim experiencing the trauma is often busy surviving or simply moving through the stages of shock, horror or grief. The world as the victim knows it, is shattered and falls messily into disjointed bits and pieces. Things don't make sense and nothing comforts. When at last she is safe, her life as she knew it is now over.

On the outside, she looks normal to family, friends and supporters who want to help but don't really know how. So they advise her "get on" with her life, now that she is safe. The simple truth is that she can't just "get on" with her life. She needs to process her predicament and make some sense of it. She has a profound need to reorient to life itself. There is much work to be done, before a victim becomes a survivor. And even more work after that to thrive and triumph.

It is this work that is so important. Neither justice nor healing can be achieved until that work is done and the victim emerges well and whole.

Abuse, especially repetitive abuse, leaves a lasting "impression" on the health, well-being and post-abuse functioning of the victim. This impact lingers long after the bruises fade, the bones mend and the abuse is over.

Still, many domestic violence survivors don't understand the lasting effects of violence. Along with their friends and relatives, and along with those who serve them in the domestic violence advocacy, medical and law enforcement communities, they fail to understand how significantly this lingering imprint of violence is affecting their well-being and their ability to function and carry on a normal life. Victims of abuse do indeed carry their own unique burden.

What I am saying to you here is that intimate partner violence *is* a healthcare issue.

Consider these facts from recent studies:

- Most healthcare visits are made because of common symptoms for which no identified pathology is found.<sup>1</sup>
- 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 the health care costs generated by these victims.<sup>2</sup>
- Most healthcare visits by victims of domestic violence are not domestic violence patients presenting with injuries, but *rather medical* problems that are *not* related to current or past injuries.
- The reach of violence across the lifespan of the victim is long. Adults who were abused in childhood vs. those who were not have more infectious diseases, mental health disorders, and other diseases such as hypertension, diabetes, dermatitis, asthma, allergy, acne, and abnormal menstrual bleeding. They also have higher rates of adult behaviors that have the potential for creating or worsening existing health problems. These behaviors include smoking, the use of alcohol, driving while intoxicated, avoiding regular gynecological examinations, not wearing seat belts, sedentary lifestyle, and high-risk sexual encounters.<sup>3</sup>
- Approximately 14% domestic violence victims have only been victimized verbally and psychologically, not physically. These victims have higher rates of numerous medical problems that the non-abused do not have. Among them:
  - Disability preventing work
  - Arthritis
  - Chronic pain
  - Migraine and other frequent headaches
  - Stammering
  - Sexually transmitted infections
  - Chronic pelvic pain
  - Stomach ulcers
  - Spastic colon (irritable bowel syndrome)

- Frequent indigestion, diarrhea or constipation.

Last but not least, recent case reports in the medical literature describe Transient Ischemic Attacks, which are small strokes, and Cardio Vascular Accidents, which are serious strokes, to be associated with strangulation injuries. This is important because almost one out of four women seeking emergency department help for domestic violence assaults sustained a strangulation injury as part of the attack. Think about this. *One out of four.*<sup>4</sup>

IPV is not cheap. The suffering of the victims is profound and 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.<sup>5</sup>

But there is hope. **There is life after abuse.** Many victims emerge stronger than before the abuse occurred in their life.

I continue to be encouraged by a Chicago bus driver who shuttled busload after busload from the airport to the hotel where a huge convention on domestic violence was headquartered. Our van was filled with people and chatter. Before we pulled away from the curb, the driver turned around and asked how many of us were going to the "big domestic violence conference." Every hand went up. She nodded and

began to drive to the hotel. A few minutes later, she announced: "I used to be one of those women."

She paused and fixed us in her gaze through the rearview mirror. Then she continued, "But I got out. I *was* a victim, but now I am a *victor*."

### **So how does a victim become a victor?**

First, she becomes safe. And then she *must become well*. Because until she does she continues to suffer from the numerous ills of domestic violence and her ability to function and adequately care for herself and children is severely impaired.

Ladies and Gentlemen, we have much to do. And we can all do something.

When I was in Dallas, our neighborhood Girl Scout troop completed a first aid course. Shortly after this, one girl in the troop witnessed an auto accident. The next day she told her troop leader all about it. "Here was this man with a cut arm," she said. "And blood was everywhere. But I knew just what to do."

"Well, good," said her leader. "And you did what you learned in our first aid class?"

"Oh yes, ma'am," the girl said proudly. "I immediately sat down on the curb

and put my head between my legs so I wouldn't faint!"

I like this little girl. She is a very smart young lady. She instinctively knew to first take good care of herself so that she could better care for others. And she demonstrated one of the most powerful philosophical approaches to life when facing confusing and overwhelming conditions. That advice, to paraphrase Theodore Roosevelt, is this:

*Do what you can,  
With what you have,  
Right here,  
Right now.<sup>6</sup>*

Let us all honor, celebrate and support STAND. Let us do what we can, with what we have, right here, right now.

## **Thank you.**

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<sup>1</sup> Katon W, Sullivan M, Walker, E: Medical Symptoms without Identified Pathology: Relationship to Psychiatric disorders, childhood and Adult Trauma, and Personality Traits. *Ann of Internal Medicine*. 2000;134(9, part 2):917-925.

<sup>2</sup> Butterfield MI, Panzer PG, Forneris CA: Victimization of women and its impact on assessment and treatment in the psychiatric emergency setting. *Psychiatric Clinics of North America*. 1999;22(4):875-896.

<sup>3</sup> Walker EA, Gelfand A, Katon W, Koss MP, Von Korff M, Bernstein D, Russo, J: Adult health status of women with histories of childhood abuse and neglect. *Am J Med*. 1999;107(4):332-339.

<sup>4</sup> Berrios DC, Grady D: Domestic violence: risk factors and outcomes. *Western J Med*. 1991;155(2):133-142.

<sup>5</sup> Scott JL: Violence as a public health emergency. *Em Med Clinics North America*. 1999;17(3): 567-573.

<sup>6</sup> <http://www.hedgesconsulting.com/>