

# Patterns of Medication Use Among Women Survivors of Intimate Partner Violence

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## ABSTRACT

**Objective:** Our objective was to describe patterns of medication use in a convenience sample of 309 women with a history of intimate partner violence (IPV) participating in a study of women's health after leaving an abusive partner (WHES).

**Methods:** Using data collected through interviews and health assessments, frequencies of past-month use of medications; abuse experienced, health problems and medical diagnoses; and selected demographics were calculated. Associations among abuse history, employment status, health problems, diagnoses, and medications were explored. Comparisons of rates of medication use in women in the WHES and the Canadian Community Health Survey (CCHS) 2.1 were calculated.

**Findings:** Almost half of participants were taking pain and/or psychotropic medications, with almost one third taking antidepressants. Child abuse history, adult sexual assault history and unemployment were associated with taking psychotropic medications. Overall rates of medication use were similar to those of Canadian women of similar age in the CCHS 2.1. However, women in the WHES were more likely to be taking antidepressants, anxiolytics and inhalants, and less likely to be taking oral contraceptives, over-the counter (OTC) pain relievers, and OTC cough and cold medications.

**Conclusion:** The pattern of medication use in women who have experienced IPV differs from that in the general population. The complex associations found among health problems, employment, diagnoses, and medication use highlight the need to consider treatment patterns within the context of the impact of lifetime abuse, economic survival, and parenting demands. Medication use must be understood as only one of a range of health interventions available to assist abused women to promote their health.

**MeSH terms:** Domestic violence; spousal violence; prescription drugs; non-prescription drugs; therapeutics

*La traduction du résumé se trouve à la fin de l'article.*

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Intimate partner violence (IPV) is a serious public health problem which results in acute injuries, affects physical and mental health, and leads to potentially harmful health-related behaviours.<sup>1</sup> However, the long-term health effects of IPV once a woman has left her abusive partner have not been investigated. Furthermore, little is known about medication use among these women. In general, a larger proportion of Canadian women than men take medication, although why some women are more likely to take medications than other women is poorly understood.<sup>2</sup> Social roles, particularly the quality of partner relationships, have been suggested as one factor that might affect medication use.<sup>2</sup> Since the early studies of violence against women, researchers have raised concerns regarding prescribing patterns for women with signs of abuse.<sup>3-5</sup> We examined patterns of prescription and over-the-counter (OTC) medication use among 309 Canadian women who had left their abusive partners, in the context of their self-reports of health problems, medical diagnoses, and abuse histories.

## METHODS

We analyzed selected data collected in Wave 1 of the Women's Health Effects study (WHES), the first Canadian prospective investigation of women's physical and mental health in the early years after leaving their abusive male partners.<sup>6</sup> Ethical approval was received from each of the universities with which the investigators are affiliated. Using newspaper, radio, and TV advertising, and posters in community locations such as health clinics, libraries, and recreational facilities, we recruited a community convenience sample of 309 adult, English-speaking women from Ontario, New Brunswick, and British Columbia who met the inclusion criteria of having a) left an abusive partner (index partner) at least 3 months, but no more than 3 years, previously, and b) screened positive on the Abuse Assessment Screen.<sup>7</sup> Data were collected using life history calendars, structured interviews, as well as in-depth abuse histories and health assessments conducted by Registered Nurses.

Abuse history was measured using single-item self-reports (yes/no) asking whether women had: a) been abused as children, b) experienced harassment from their

index partners since leaving, and c) ever been sexually assaulted as an adult other than by the index partner. Health problems in past month were assessed using women's self-reports (yes/no) to a list of 43 health problems (symptoms, signs, common concerns) that have been associated with IPV. Similarly, current smoking was measured by a self-report question (yes/no). Additionally, women were asked to list current diagnoses made by a health professional. Regarding medication use, women were asked, "Have you taken any prescription drugs in the past month?" Medication names were gathered from those who replied affirmatively. These questions were repeated for over-the-counter (OTC) medications. Because most interviews were conducted in women's homes where women had access to medications taken in the past month, the accuracy of these data was enhanced.

Descriptive statistics were computed for demographic and health problem data. Diagnoses were categorized according to the ICD-10.<sup>8</sup> Prescription drugs were classified by drug group, subclassification, and drug name according to the Anatomical Therapeutic Chemical Classification modified for national health surveys in Canada.<sup>9</sup> Chi-square analysis was used to explore associations between medication use and abuse history, employment, common diagnoses, and related health problems. Additionally, chi-square analysis was used to determine whether the WHES sample differed from a population sample of Canadian women aged 20-59 with respect to past-month medication use in general and use of selected drugs, using data from the public access microdata file of the Canadian Community Health Survey 2.1 (CCHS) (2003).

## RESULTS

Demographic characteristics, abuse history, selected health indicators, and rates of medication use for the 309 women surveyed are reported in Table I. The most frequent self-reported diagnoses and health problems are listed in Table II. Frequencies of prescription and OTC medication use, organized by classification and common subclassification, are reported in Table III.

Almost half (49.8%, n=154) of the women surveyed reported taking prescrip-

**TABLE I**  
**Characteristics of Sample (N=309)**

Characteristics	Descriptive Statistics
Age in years: Mean (SD); Range	39.4 (9.8); 19 to 63
Time Out* in Months at Interview: Mean (SD); Range	20.9 (10.2); 3 to 40.5
Education in Years: Mean (SD); Range	13.4 (2.6); 6 to 22
Income in dollars: Mean (SD); Median; Range	20,391 (17,145); 15,684; 0 to 95,000
Dependent Children	57%
Employed	45%
Other Income Sources	
Social Assistance	31.4%
Disability Pension	10.7%
Visible Minority	16.8%
Aboriginal Heritage	7.4%
Geographic Profile (n=304)	
Large Metropolitan Area (250,000+)	45.7%
Medium City (50,000-249,999)	24.3%
Small City (20,000-49,999)	5.6%
Small Towns and Rural Communities (<20,000)	24.3%
Visited a General Practitioner in Past Month	56%
Currently Smoking (n=306)	45.1%
Abused as a Child	66.3%
Adult Sexual Assault	39.5%
Harassment Since Leaving	83.4%
Cumulative Abuse	
IPV, Child Abuse, Harassment, Adult Sexual Assault	26.5 %
IPV alone	3.9%
Medication Use	
Prescription and/or OTC Medication	90.9%
Prescription Medications	69.9%
OTC Medications	76.4%
Number of Prescription Medications: Mean (SD); Range	3.2 (2.61); 1 to 14
Number of OTC Medications: Mean (SD); Range	1.7 (1.06); 1 to 7
Number of Current Diagnoses: Mean (SD); Range	3.1 (2.9); 0 to 19
Number of Current Health Problems: Mean (SD); Range	12.7 (6.7); 0 to 32

\* Time out of abusive relationship at time of interview

**TABLE II**  
**Frequency of Self-reported Medical Diagnoses and Health Problems (N=309)**

Diagnosis	Percent	Health Problem	Percent
Depression (chronic and acute)	31.1	Feeling worried or uptight	79.9
Arthritis	16.8	Fatigue	74.1
Back disorders and injuries	13.9	Feeling sad or depressed	73.1
Migraines and headaches	13.6	Difficulty sleeping	68.9
Anxiety disorders	13.3	Back pain	63.4
Asthma	13.3	Headaches	62.8
Irritable bowel disease	11.0	Difficulty concentrating	59.2
Hypertension	8.7	Aches, pains & muscle soreness	50.5
Allergies	7.4	Bowel problems	49.2
Post-traumatic stress disorder	7.1	Upset stomach or heartburn	46.3
Sleep disorders	6.5	Memory loss	42.7
Hyperlipidemia	5.8	Swollen, painful joints	42.4
Hypothyroidism	5.8	Loss of appetite	40.8
		Dizzy spells	38.5
		Nausea/vomiting	37.5
		Panic attacks	29.9
		Heart palpitations	29.4
		Poor bladder control	27.8
		Ringing in the ears	27.5
		Difficulty breathing	26.2
		Disordered eating	26.2
		Dental problems	25.6
		Difficulty hearing	24.6
		Chest pain	24.6

tion medications for the nervous system, with 43.6% (n=135) taking psychotropic medications (antidepressants, anxiolytics, antipsychotics, antiepileptics, hypnotics and sedatives) and 15.2% taking pain medications (analgesics, opioids, anti-migraine). Women with a history of child abuse were more likely to be taking prescription pain medications ( $\chi^2=5.44$ ,

$p=0.02$ ) and psychotropics, ( $\chi^2=12.97$ ,  $p<0.001$ ), particularly antidepressants ( $\chi^2=10.00$ ,  $p=0.003$ ). A history of adult sexual assault was associated with taking antidepressants ( $\chi^2=5.16$ ,  $p=0.02$ ) and antipsychotics ( $\chi^2=10.32$ ,  $p=0.001$ ). Women were less likely to be currently employed if they were taking psychotropic medications ( $\chi^2=5.03$ ,  $p=0.03$ ), particu-

**TABLE III**  
**Frequency of Prescription and OTC Medication by Classification (N=309)**

Drug Classification	Prescription	Percent	OTC	Percent
<b>Nervous System</b>		<b>49.8</b>		<b>41.4</b>
Pain		15.2		41.1
	Analgesics & antipyretics	8.4	Acetaminophen	33.7
	Opioids	7.1	Aspirin	5.8
	Anti-migraine	1.9		
Psychotropics		43.6		
	Antidepressants	31.1		
	Anxiolytics	11.3		
	Antiepileptics	10.4		
	Antipsychotics	8.1		
	Hypnotics and sedatives	6.8		
<b>Alimentary Tract &amp; Metabolism</b>		<b>16.8</b>		<b>9.1</b>
	Peptic ulcer and GERD	12.6	Antacids	2.3
	Oral blood glucose lowering agents	2.6	Drugs for peptic ulcers	1.6
	Insulin and analogs	1.3	Laxatives	1.3
			Calcium	1.3
<b>Genitourinary &amp; Sex Hormones</b>		<b>12.9</b>		
	Contraceptives	5.8		
	Progestens & estrogens	7.4		
<b>Musculoskeletal</b>		<b>12.9</b>		<b>39.8</b>
	NSAIDs	10.0	Ibuprophen	37.2
	Muscle relaxants	3.6		
<b>Cardiovascular</b>		<b>12.9</b>		
	Cholesterol reducers	4.2		
	Diuretics	4.2		
	ACE inhibitors	3.6		
	Beta-blockers	2.9		
	Antihypertensives	1.9		
	Calcium channel blockers	0.6		
	Vasodilators	0.6		
<b>Respiratory</b>		<b>12.0</b>		<b>12.0</b>
	Inhalants	11.0	Antihistamines	6.8
			OTC cough & cold remedies	5.7
<b>Anti-infectives</b>		<b>9.7</b>		
	Anti-bacterials	7.1		
	Anti-virals	2.3		
<b>Systemic Hormonal Preparations</b>		<b>6.5</b>		
	Thyroid medication	5.8		

ly antidepressants ( $\chi^2=4.09$ ,  $p=0.04$ ) and antipsychotics ( $\chi^2=9.23$ ,  $p=0.002$ ). No relationships were found between harassment since leaving and the use of psychotropics or between smoking and the use of inhalers. The most common OTC medications taken were those for the nervous system (41.4%,  $n=128$ ), specifically analgesics. A history of child abuse was associated with taking OTC medications ( $\chi^2=4.29$ ,  $p=0.04$ ). Musculoskeletal OTC medications, mainly non-steroidal anti-inflammatory drugs (NSAID) were reported by 39.8% ( $n=123$ ) women. Being employed was associated with taking OTC musculoskeletal medication ( $\chi^2=5.1$ ,  $p=0.03$ ).

Results of chi-square analysis suggest that women were more likely to be taking specific classifications of medications if they had been diagnosed or were experiencing health problems for which these medications are considered to be a standard treatment. A notable exception is the

non-significant association between a diagnosis of Post-traumatic Stress Disorder (PTSD) and taking psychotropic medications ( $\chi^2=1.14$ ,  $p=0.287$ ). Only 54.6% ( $n=12$ ) of women diagnosed with PTSD were taking psychotropic medications.

Analysis of data from the CCHS 2.1 survey revealed that 88.1% of women aged 20-59 reported taking prescription and/or non-prescription medication in the past month. No significant difference was found between the proportions of women taking any medication in the WHES (90.9%) and the CCHS ( $\chi^2=2.31$ , ns). In Table IV, we report the percentages of affirmative responses to questions about specific medication use in the past month in the CCHS, the percentages of past month use of analogous medications in the WHES sample, and the Chi-square comparisons used to determine whether the WHES sample differs from the general population of the CCHS with respect to use of each medication.

## DISCUSSION

Although women in our sample were experiencing considerable health challenges for which medications might be helpful, women in the WHES sample were no more likely to be taking medication than Canadian women in general of similar age. However, there were differences in the pattern of medication use. The WHES sample was less likely to be taking OTC NSAIDs and analgesics, and no more likely to be taking opioids than Canadian women in general, even though the incidence of chronic pain is quite different. Using 2000-2001 CCHS data, 18% of Canadian women have been estimated to suffer from chronic pain,<sup>10</sup> while two thirds of women in our sample reported problems with back pain and headaches and more than 40% reported swollen painful joints. In the context of these health problems, rates of analgesic and NSAID use do not seem high, and we question whether women who have left abusive partners may, in fact, be under-using these medications. The association found between employment and use of OTC NSAIDs suggests the need to explore whether employment is a consequence or cause of NSAID use and how affordability of OTC NSAIDs affects their use.

Women in the WHES sample were less likely to be taking oral contraceptives. In order to understand whether the low use of oral contraceptives is a concern, further research is needed regarding sexual health practices among women after their leaving abusive partners. Women in the WHES were also less likely to be taking OTC cough and cold medications. Because data for both studies were collected year round, this finding cannot be attributed to seasonal differences. However, given the relatively low incomes of women in the WHES, and lack of coverage for OTC medications on provincial drug plans, it is possible that lower rates of use reflect women's inability to pay for cough and cold medications even if required. Notably, women in the WHES were more likely to use inhalers. Although 43% of WHES participants smoked as compared with 20% of Canadian women over 15,<sup>11</sup> the higher smoking rate did not account for the higher rate of inhaler use.

Of particular concern is the finding that women in the WHES sample were more

TABLE IV

## Past-month Medications Use by Women Aged 20-59 CCHS 2.1 vs. WHES

CCHS 2.1 Question <sup>21</sup> In the past month did you take...	Percent of CCHS "Yes"	Percent of WHES Taking Similar Medications	Chi-Square (1 df)
Pain relievers such as Aspirin or Tylenol including arthritis medicine and anti-inflammatories?	76.1	70.9	$\chi^2=4.59$ , $p<0.05^*$
Tranquilizers such as Valium or Ativan?	3.8	11.3	$\chi^2=47.55$ , $p<0.001^*$
Anti-depressants such as Prozac, Paxil, or Effexor?	9.5	31.3	$\chi^2=170.80$ , $p<0.001^*$
Codeine, Demerol or Morphine?	9.3	9.7	$\chi^2=0.06$ , NS
Asthma medications such as inhalers or nebulizers?	5.5	11	$\chi^2=17.98$ , $p<0.001^*$
Cough or cold remedies?	23.4	12	$\chi^2=22.40$ , $p<0.001^*$
Penicillin or other antibiotics?	10.4	7.1	$\chi^2=3.6$ , NS
Birth control pills?	16.6	5.8	$\chi^2=26.03$ , $p<0.001^*$
Thyroid medication such as Synthroid or Levothyroxine?	6.3	5.8	$\chi^2=0.13$ , NS

likely to be taking psychotropic medications, specifically anxiolytics and anti-depressants. Although rates of anxiety disorders were similar in the WHES sample (14.9%) to Canadian women generally (16%),<sup>12</sup> 11.3% of women in our sample took anxiolytics as compared to 3.8% in the CCHS. This finding warrants further exploration given current concern regarding the side effects, addiction, and recovery from anxiolytic (benzodiazepine) use beyond two weeks.<sup>13</sup> In contrast, the significant difference in the rates of antidepressant (31.1% WHES vs. 9.5% CCHS) was more aligned with differences in rates of depression across the samples (i.e., 31.1% in WHES vs. 5.7% in the general population of Canadian women aged 12 and older<sup>14</sup>). Additionally, rates of depression have been reported to be more than twice as high among lone mothers as compared to other women (15.4% vs. 6.8%),<sup>15</sup> and over half of women in our sample were single mothers of dependent children. Medications are very likely to be prescribed when a psychiatric diagnosis is made.<sup>16</sup> Psychiatric diagnoses are imprecise, may obscure chronic social inequities such as violence and poverty, and may have negative consequences for lone mothers such as loss of child custody.<sup>16</sup> Further investigation is needed to understand the linkages among depression diagnosis, medication use, the trauma of IPV, and the challenges of single parenting.

Findings from the WHES study suggest that lifetime experiences of child abuse and adult sexual assault along with IPV are important markers for use of psychotropics, particularly anti-depressants and antipsychotics, and pain relievers. In a secondary analysis of the US National Violence Against Women Survey, women with a history of physical or sexual abuse were found to have an adjusted relative risk (aRR) of 2.2 for tranquilizer use, 2.5 for

anti-depressant use, and 1.8 for painkillers, while coercive control alone resulted in aRRs of 1.9, 2.1 and 1.8, respectively.<sup>17</sup> Although helpful for symptom relief, many psychotropic medications have adverse side effects that may affect quality of life,<sup>18</sup> and some, such as antipsychotic drugs, affect women differently than men.<sup>19</sup> Although we found that antipsychotic or antidepressant use was associated with unemployment, further study is needed to uncover the sequence of these events in order to fully understand how IPV affects women's ability to be economically self-sufficient.

A limitation of our study is the non-representative nature of the sample. However, most knowledge of women's health after their leaving abusive partners is based on cross-sectional US studies of women in shelters. By recruiting a community sample of women in three Canadian provinces, we begin to address the gap in knowledge about the health of a wider population of Canadian women survivors of IPV. The high rates of health problems and diagnoses reported in the WHES study support previously documented health consequences of IPV.<sup>20</sup> Our findings challenge a prevailing belief that more women who have been abused take medications than women in the general population. However, the pattern of medication use in women who have left abusive partners is different and may reflect the negative impact of violence on the health of women survivors of IPV, particularly in the form of anxiety and depression. The association between lifetime abuse history and use of psychotropic and pain medications supports the importance of understanding not only the effects of a history of IPV but also of child abuse and adult sexual assault. The complex relationships found among health problems, employment, diagnoses, and medication use highlight the need for a holistic, social determinants

approach to treatment in the context of the impact of lifetime abuse, economic survival, and parenting demands. Our findings support the need for education of health care providers to focus on the synergy among health, economic, and social consequences of women's lifetime abuse experiences. Medication use must be understood as only *one* of a range of health interventions available to assist abused women to promote their health.

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## RÉSUMÉ

**Objectif :** Décrire les habitudes de consommation de médicaments au sein d'un échantillon de commodité de 309 femmes victimes de violence entre partenaires intimes (VPI) ayant participé à une enquête sur la santé des femmes (WHES) après avoir quitté un partenaire violent.

**Méthode :** À la faveur d'entretiens et d'évaluations de l'état de santé, nous avons déterminé la fréquence de consommation de médicaments au cours du mois antérieur, la violence subie, les problèmes de santé et les diagnostics médicaux, et établi certaines données démographiques. Les liens entre les antécédents de mauvais traitements, l'emploi, les problèmes de santé, les diagnostics et les médicaments ont été analysés. Nous avons ensuite comparé les taux de consommation de médicaments par les femmes de l'enquête WHES et de l'Enquête sur la santé dans les collectivités canadiennes (ESCC), cycle 2.1.

**Résultats :** Près de la moitié des participantes prenaient des analgésiques et/ou des médicaments psychotropes, et près du tiers prenaient des antidépresseurs. Les antécédents de mauvais traitements durant l'enfance, d'agression sexuelle à l'âge adulte et de chômage étaient associés à la consommation de médicaments psychotropes. Dans l'ensemble, les taux de consommation de médicaments étaient semblables à ceux des Canadiennes du même âge recensées dans l'ESCC 2.1. Toutefois, les participantes de l'enquête WHES étaient plus susceptibles de prendre des antidépresseurs, des anxiolytiques et des inhalants et moins susceptibles de prendre des contraceptifs oraux, des analgésiques en vente libre et des médicaments contre la toux et le rhume en vente libre.

**Conclusion :** Les femmes victimes de VPI n'ont pas les mêmes habitudes de consommation de médicaments que leurs concitoyennes. Les liens complexes que nous avons observés entre les problèmes de santé, l'emploi, les diagnostics et la consommation de médicaments montrent qu'il faut étudier les modes de traitement en fonction des répercussions de la violence subie au cours de la vie, de la survie économique et des exigences du rôle parental. Les médicaments ne sont qu'un des nombreux outils disponibles pour aider les femmes maltraitées à retrouver la santé.

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